Supreme Court, U.S.
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No.

In the Supreme Court of the United States

JOHN J. KANE REGIONAL CENTERS - GLEN HAZEL,
PETITIONER

v.

SARAH GRAMMER, AS ADMINISTRATRIX OF THE ESTATE
OF MELVINTEEN DANIELS

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

In 1987, Congress enacted the Federal Nursing Home Reform Amendments (FNHRA) as part of an omnibus spending bill. Among other things, FNHRA amended the Medicaid Act to condition a State's receipt of federal funding on the State adopting a plan, approved by the Secretary of Health and Human Services, that requires nursing facilities to comply with certain requirements in order to participate in the State's Medicaid program. *See* 42 U.S.C. §§ 1396a(a)(28), 1396r. Generally speaking, Medicaid-participating nursing facilities must maintain substantial compliance with the requirements in order for a State to receive federal matching funds, and even instances of serious noncompliance by individual facilities may be dealt with using alternative remedies other than the denial of payment. A divided panel of the court of appeals below held that Medicaid beneficiaries can sue government-operated nursing facilities for damages under 42 U.S.C. § 1983 because FNHRA unambiguously confers individually enforceable "rights." The questions presented are as follows:

1. Whether, in the absence of an express private right of action, Spending Clause legislation establishing requirements for federal-state cooperative programs can unambiguously confer "rights" enforceable by third-party beneficiaries under 42 U.S.C. § 1983.

2. Whether, if the answer to Question 1 is "yes," FNHRA unambiguously confers "rights" enforceable by Medicaid beneficiaries under 42 U.S.C. § 1983.

RULE 29.6 CORPORATE DISCLOSURE STATEMENT

Petitioner John J. Kane Regional Centers - Glen Hazel is a nursing facility owned and operated by Allegheny County, Pennsylvania. No publicly held company owns a 10 percent or greater ownership interest in petitioner.

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ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

Petitioner John J. Kane Regional Centers - Glen Hazel (the Kane Center) respectfully submits this petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Third Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-28a) is reported at 570 F.3d 520. The order of the district court adopting the magistrate judge's report and recommendation (App., *infra*, 29a-30a) and the magistrate judge's report and recommendation (App., *infra*, 31a-46a) are not published in the *Federal Supplement*, but are available at 2007 WL 1087751.

JURISDICTION

The judgment of the court of appeals was entered on June 30, 2009. The court of appeals denied the Kane Center's timely petition for panel rehearing and rehearing en banc on August 14, 2009 (App., *infra*, 47a-48a). On October 22, 2009, Justice Alito extended the time within which to file a petition for a writ of certiorari to and including December 14, 2009. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Article I, Section 8, Clause 1 of the United States Constitution (Spending Clause) provides:

> The Congress shall have Power to lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States . . . .

Title 42 U.S.C. § 1983 provides, in relevant part:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress . . . .

Relevant provisions of the Medicaid Act, 42 U.S.C. §§ 1396-1396v, as well as § 1 of the Civil Rights Act of 1871, ch. 22, 17 Stat. 13, and Rev. Stat. § 1979, are

reprinted in an appendix to this petition (App., *infra*, 49a-134a).

STATEMENT

This case is a medical malpractice action disguised as a civil rights action. Relying on various provisions of the Medicaid Act, respondent Sarah Grammer filed suit against the Kane Center, which is a county-operated nursing facility located in Pittsburgh, Pennsylvania. Ms. Grammer alleged that the Kane Center deprived Ms. Grammer's mother of her civil rights by breaching a statutory duty to ensure quality care. The district court dismissed Ms. Grammer's complaint after finding that the Spending Clause legislation in question did not unambiguously confer individually enforceable "rights," the violation of which may be remedied by damages suits under 42 U.S.C. § 1983. A divided panel of the court of appeals reinstated Ms. Grammer's suit.

1. a. The Medicaid Act establishes a cooperative federal-state program that provides federal matching funds to States that choose to pay for medical services on behalf of certain low-income and disabled individuals. The purpose of the Medicaid program is to "enabl[e] each State, as far as practicable under the conditions in such State, to furnish . . . medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396.

In order to participate in the Medicaid program, a State must submit a plan for medical assistance to the Centers for Medicare & Medicaid Services (CMS), which administers Medicaid on behalf of the

Secretary of Health and Human Services. §§ 1396, 1396a. Among other things, the state plan must list the categories of individuals who will receive medical assistance and the specific kinds of medical care and services that will be covered. § 1396a. "Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services." 42 C.F.R. § 430.0.

If the state plan is approved by the Secretary, the State is thereafter eligible to be reimbursed by the Federal Government for a specified percentage of the amounts expended by the State as medical assistance under the state plan. 42 U.S.C. §§ 1396b(a)(1), 1396d(b). However, the Secretary may withhold federal matching funds in full or in part if a state plan "has been so changed that it no longer complies with the provisions of section 1396a of this title," or if, "in the administration of the plan there is a failure to comply substantially with any such provision." § 1396c.

b. In 1987, Congress enacted the Federal Nursing Home Reform Amendments (FNHRA) as part of a larger spending bill. *See* Omnibus Reconciliation Act of 1987 (OBRA), Pub. L. No. 100-203, tit. IV, subtit. C, 101 Stat. 1330, 1330-160 through 1330-221. In relevant part, FNHRA amended the Medicaid Act to require that state plans provide that "any nursing facility receiving payments under such plan must satisfy all the requirements of subsections (b) through (d) of section 1396r of this title as they apply to such facilities." 42 U.S.C. § 1396a(a)(28).

The provisions cross-referenced by § 1396a(a)(28) establish a wide variety of requirements for Medicaid-participating nursing facilities, the vast majority of which are also imposed on Medicare-participating nursing facilities. *See* 42 U.S.C. § 1395i-3. FNHRA organizes those requirements into 3 categories:

(1) "Requirements relating to provision of services," § 1396r(b);

(2) "Requirements related to resident's rights," § 1396r(c); and

(3) "Requirements relating to administration and other matters," § 1396r(d).

As is relevant here, the first category of FNHRA's requirements instructs that a Medicaid-participating nursing facility must "care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident." § 1396r(b)(1)(A). Such facilities must "provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care which . . . is periodically reviewed and revised." § 1396r(b)(2)(C). The written plan of care must "describe[] the medical, nursing, and psychosocial needs of the resident and how such needs will be met." § 1396r(b)(2)(A).

The first category of FNHRA's requirements also instructs that a Medicaid-participating nursing facility "must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity" promptly and revise such assessments, as appropriate, following a reexamination of the resident "no less frequently than once every 3

months." § 1396r(b)(3)(C). The results from such assessments "shall be used in developing, reviewing, and revising the resident's plan of care." § 1396r(b)(3)(D).

Medicaid-participating nursing facilities must also provide "medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident"; "dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident"; and "an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident." § 1396r(b)(4)(A)(ii), (iv), (v). The foregoing services must be provided "by qualified persons in accordance with each resident's written plan of care," § 1396r(b)(4)(B), and participating facilities must "maintain clinical records on all residents," § 1396r(b)(6)(C).

Under the second category of requirements—"[r]equirements related to resident's rights"—FNHRA instructs that Medicaid-participating nursing facilities "must protect and promote the rights of each resident, including" the "right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms." § 1396r(c)(1)(A)(ii). "Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan . . . for which the drugs are prescribed and only if, at least annually an independent, external con-

sultant reviews the appropriateness of the drug plan of each resident receiving such drugs." § 1396r(c)(1)(D).

Under the third category of requirements—"[r]equirements relating to administration and other matters"—FNHRA instructs that a Medicaid-participating nursing facility "must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." § 1396r(d)(1)(A). In addition, a Medicaid-participating nursing facility's administrator "must meet standards established by the Secretary," § 1396r(d)(1)(C), and the facility "must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations . . . and with accepted professional standards and principles which apply to professionals providing services in such a facility," § 1396r(d)(4)(A).

FNHRA does not contain an express private right of action authorizing Medicaid beneficiaries to sue to enforce the statute's requirements. Instead, FNHRA established an elaborate administrative inspection and regulatory enforcement process to ensure that federal matching funds are well spent. "Under each State plan under this subchapter," FNHRA instructs that the "State shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of nursing facilities (other than facilities of the State) with the requirements of subsections (b), (c), and (d) of this section. The Secretary shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compli-

ance of State nursing facilities with the requirements of such subsections." § 1396r(g)(1)(A).

Teams of specially trained and qualified inspectors, known as "surveyors," use unannounced inspections to determine whether nursing facilities are in "substantial compliance" with the requirements governing participation in the Medicaid program. *See* 42 U.S.C. § 1396r(g); 42 C.F.R. §§ 488.26, 488.301, 488.330(b)(1). "Substantial compliance" means a "level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301.

By statute, the survey team must include a "multidisciplinary team of professionals," including at least one registered nurse. 42 U.S.C. § 1396r(g)(2)(E). Surveyors must use a "case-mix stratified sample of residents" to evaluate "the quality of care furnished, as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition surveys, activities and social participation, and sanitation, infection control, and physical environment." § 1396r(g)(2)(A)(ii). Surveyors are to "directly observe the actual provision of care and services to residents, and the effects of that care, to assess whether the care provided meets the needs of individual residents." 42 C.F.R. § 488.26(c)(2). Failure to utilize the prescribed protocol renders the results of the inspection invalid. § 488.26(c)(4).

A finding that a nursing facility is not in substantial compliance with FNHRA's conditions of Medicaid participation does not necessarily preclude the facility from receiving payments from the State or the

State from receiving federal matching funds for its payments to the facility. Instead, FNHRA and its implementing regulations provide CMS and participating States with substantial discretion to impose a wide variety of remedies to promote compliance, including civil money penalties and placement of a temporary manager or state monitor in the facility. *See* 42 U.S.C. § 1396r(h)(3)(C); 42 C.F.R. §§ 488.406, 488.408. Even for a nursing facility that is not in substantial compliance, if the State finds it is more appropriate to impose alternative remedies than to terminate the facility's Medicaid participation, FNHRA expressly provides that federal matching funds can still be paid to the State. 42 U.S.C. § 1396r(h)(3)(D).

In order to select the appropriate remedy, surveyors are required to classify deficiency findings by seriousness. 42 C.F.R. § 488.404(b). Seriousness is assessed by evaluating the severity of the deficiency (i.e., the degree of actual and potential harm), in conjunction with the scope of the deficiency (i.e., the degree to which it is pervasive or isolated). §§ 488.404(b), 488.404(e)(i)-(iii), 488.410(a). Regardless of the remedy imposed, the facility must submit a plan of correction unless the deficiencies identified are isolated and present no more than a potential for minimal harm. §§ 488.402(d), 488.408(f)(2).

A Medicaid-participating nursing facility may appeal the imposition of a remedy to the Departmental Appeals Board (DAB) within the Department of Health and Human Services. 42 C.F.R. §§ 488.330(e)(3), 498.40. An administrative law judge adjudicates the dispute following an in-person hearing. § 498.60. Upon request, the DAB's Appel-

late Division will review the decision of the administrative law judge. § 498.80. In cases involving the imposition of civil money penalties, a facility may appeal the Appellate Division's decision to the circuit court of appeals in which the facility is located. *See* 42 U.S.C. § 1320a-7a(e); 42 C.F.R. § 498.95.

2. The Commonwealth of Pennsylvania has chosen to participate in the Medicaid program. The Kane Center, in turn, is a Medicaid-participating nursing facility operated by Allegheny County, Pennsylvania. Respondent Sarah Grammer's mother, Melvinteen Daniels, was a Medicaid beneficiary who resided at the Kane Center.

In 2006, Ms. Grammer sued the Kane Center in the United States District Court for the Western District of Pennsylvania. Ms. Grammer alleged that Ms. Daniels died as a result of the Kane Center's failure to provide proper medical treatment.

Asserting claims under 42 U.S.C. § 1983 for wrongful death and survival, Ms. Grammer alleged that the Kane Center deprived Ms. Daniels of her civil rights by breaching a duty to ensure quality care under FNHRA. Ms. Grammer's complaint was predicated on the laundry list of FNHRA subsections discussed above, which she alleged the Kane Center violated as a matter of custom and policy. Although her original complaint also alleged violations of federal "rights" predicated on CMS regulations, Ms. Grammer later abandoned those allegations in the course of proceedings before the district court.

Ms. Grammer's complaint did not allege that Pennsylvania's state plan failed to comply with 42 U.S.C. § 1396a(a)(28), nor was any Pennsylvania official named as a defendant. Instead, Ms. Gram-

mer sought damages in excess of $75,000 from the Kane Center, plus attorney's fees under 42 U.S.C. § 1988.

The Kane Center moved to dismiss Ms. Grammer's complaint, arguing that FNHRA does not unambiguously confer federal "rights" on individual Medicaid beneficiaries that can be enforced via § 1983. Alternatively, the Kane Center argued that FNHRA's enforcement scheme was sufficiently comprehensive so as to demonstrate congressional intent to preclude the remedy of § 1983 suits.

3. Magistrate Judge Amy Reynolds Hay issued a report and recommendation (App., *infra*, 31a-46a) concluding that the Kane Center's motion to dismiss should be granted. The magistrate judge explained that a § 1983 plaintiff "must show that Congress intended to create an 'unambiguously conferred right' by pointing to clear and unambiguous 'rights-creating language.'" App., *infra*, 36a (quoting *Gonzaga Univ. v. Doe*, 536 U.S. 273, 283 (2002)). Citing numerous decisions that had previously held there is no implied right of action under FNHRA, the magistrate judge concluded that the statute did not contain unambiguous rights-creating language for purposes of § 1983. *Id.* at 37a-38a (citing *Solter v. Health Partners of Philadelphia, Inc.*, 215 F. Supp. 2d 533, 540 (E.D. Pa. 2002); *Brogdon ex rel. Cline v. Nat'l Healthcare Corp.*, 103 F. Supp. 2d 1322, 1330-32 (N.D. Ga. 2000); *Nichols v. St. Luke Ctr. of Hyde Park*, 800 F. Supp. 1564, 1567-68 (S.D. Ohio 1992); *Chalfin v. Beverly Enters., Inc.*, 741 F. Supp. 1162, 1166-67 (E.D. Pa. 1989); *Ratmansky ex rel. Ratmansky v. Plymouth House Nursing Home, Inc.*, No. Civ. A. 05-0610, 2005 WL 770628, at *3 (E.D. Pa.

Apr. 5, 2005); *Sparr v. Berks County*, No. Civ. A. 02-2576, 2002 WL 1608243, at *2-3 (E.D. Pa. July 18, 2002); and *Andrusichen v. Extendicare Health Servs., Inc.*, No. Civ. A. 02-674, 2002 WL 1743576, at *2-3 (E.D. Pa. July 23, 2002)).

The magistrate judge explained that FNHRA "merely sets forth the requirements that the Secretary of Health and Human Services must implement and the services that the state must require nursing facilities to provide if the state wants to qualify for federal funding. Thus, the statute imposes a duty only on states which choose to participate in the program and not on the nursing homes that provide medical services." *Id.* at 41a. "Because the Medicaid Act speaks to the states and their obligations thereunder," the magistrate judge reasoned, "it follows the states should be held accountable by those who are ultimately harmed when the state does not fulfill its obligations. It does not follow that an individual may bring a personal injury claim against a nursing home for providing insufficient care since the statute does not impose a duty on nursing care providers." *Id.* at 42a-43a.

In arguing against dismissal, Ms. Grammer principally relied on two circuit court decisions: *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180 (3d Cir. 2004), and *Rolland v. Romney*, 318 F.3d 42 (1st Cir. 2003). In distinguishing both rulings, the magistrate judge explained that, "in both *Sabree* and *Rolland*, and in seemingly every other § 1983 case in which it was found that the Medicaid Act created an enforceable right, the case was brought against the state itself or the state agency responsible for implementing the provisions of the Medicaid Act rather than directly

against the care provider. Moreover, the relief sought by the plaintiffs was in the form of injunctive relief rather than the monetary damages sought by plaintiff here." *Id.* at 40a. This, the magistrate judge concluded, was a distinction with a difference. *Id.* at 41a.

Having found that FNHRA did not unambiguously confer federal "rights" upon individual Medicaid beneficiaries, the magistrate judge found it unnecessary to address the Kane Center's alternative argument that FNHRA's enforcement scheme was sufficiently comprehensive so as to demonstrate congressional intent to preclude the remedy of private suits under § 1983. *Id.* at 46a.

4. After receiving additional briefing from the parties, District Judge Gary Lancaster issued an order (App., *infra*, 29a-30a) adopting the magistrate judge's report and recommendation with one limited exception. The district court believed that one sentence in the magistrate judge's report and recommendation was "an overly broad interpretation of" *Gonzaga* and "superfluous to the analysis." App., *infra*, 30a. The sentence in the magistrate judge's report and recommendation read as follows: "Because *Gonzaga* instructs that where there is no implied right of action under a statute, there is no right enforceable under § 1983, it follows from these cases that plaintiff has no enforceable right under § 1983 and, thus, has failed to state a claim." App., *infra*, 38a. In all other respects, the district court adopted the magistrate judge's report and recommendation, and dismissed Ms. Grammer's complaint with prejudice.

5. a. A divided panel of the Third Circuit reversed the district court's judgment and remanded the case to the district court. App., *infra*, 1a-25a. In an opinion written by Senior Circuit Judge Richard Nygaard and joined by Circuit Judge D. Brooks Smith, the panel majority concluded that FNHRA is "sufficiently rights-creating and that the rights conferred by its various provisions are neither 'vague and amorphous' nor impose upon states a mere precatory obligation." *Id.* at 3a.

Although the analysis of *Blessing v. Freestone*, 520 U.S. 329 (1997), "may appear straightforward," the panel majority asserted that "subsequent Supreme Court decisions have suggested that there are fine distinctions in its application, requiring us to look not only at the statutory text, but also to congressional intent." *Id.* at 11a. In the opinion of the majority, *Gonzaga* "clarified the *Blessing* analysis by adding the requirement that any such right be unambiguously conferred by Congress." *Id.* The panel majority believed that under the Third Circuit's decision in *Sabree*, which had interpreted *Gonzaga*, a court first had to apply the "three components of the *Blessing* test and then, to inquire into whether the statutes in question unambiguously confer a substantive right." *Id.* at 13a-14a.

Applying the first *Blessing* factor, the panel majority found that Medicaid beneficiaries were intended beneficiaries of § 1396r, *id.* at 14a, and that § 1396r was directly concerned with whether the needs of any particular person had been satisfied, *id.* at 15a. As for the second *Blessing* factor, the majority believed that the "rights" asserted by Ms. Grammer were not "vague or amorphous"; instead,

§ 1396r's "repeated use of the phrases 'must provide,' 'must maintain' and 'must conduct' are not unduly vague or amorphous such that the judiciary cannot enforce the statutory provisions. These provisions make clear that nursing homes must provide a basic level of service and care for residents and Medicaid patients." *Id.* Turning to the last *Blessing* factor, the majority concluded that the language of § 1396r "unambiguously binds the states and the nursing homes as indicated by the repeated use of 'must.' This language is mandatory in nature and easily satisfies the third factor of the *Blessing* test." *Id.*

Satisfied that all three *Blessing* factors had been met, the panel majority then turned to the Third Circuit's interpretation of *Gonzaga*. *Sabree*, the majority explained, had applied *Gonzaga*'s heightened standard and nonetheless found that language within § 1396a was sufficiently rights-creating. *Id.* at 17a-18a. In particular, *Sabree* had examined § 1396a(a)(8), which provides that a state plan for medical assistance must "provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals."

Judged against the statutory language found to be rights-creating in *Sabree*, the panel majority believed that FNHRA was "replete with rights-creating language." *Id.* at 18a. According to the panel majority:

> The amendments confer upon residents of such facilities the right to choose their personal attending physicians, to be fully informed about and to participate in care and treatment, to be free from

> physical or mental abuse, to voice grievances and to enjoy privacy and confidentiality. . . . Nursing homes are required to care for residents in a manner promoting quality of life, provide services and activities to maintain the highest practicable physical, mental and psychosocial well-being of residents, and conduct comprehensive assessments of their functional abilities. . . . Further, the statute specifically guarantees nursing home residents the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat their medical symptoms. . . .

Id. at 18a-19a (citations omitted). That § 1396r used the word "must" and "residents" throughout supported the panel majority's belief that § 1396r was mandatory and phrased in terms of the persons benefited, respectfully. *Id.* at 19a. In contrast, the panel majority was "not concerned that the provisions relied upon by [Ms. Grammer] are phrased in terms of responsibilities imposed on the state or the nursing home." *Id.* at 20a.

Next, the panel majority explained its belief that FNHRA's legislative history was "compelling" such that it supported the majority's conclusion that § 1396r created "rights" enforceable via § 1983. *Id.* at 20a. The apparent basis for the majority's belief was a lengthy quotation from the First Circuit's decision in *Rolland*, which, in turn, had relied upon legislative history unrelated to the provisions of § 1396r upon which Ms. Grammer relied. *Id.* at 21a-22a. Specifically, *Rolland* had cited a portion of a

House report regarding the improper placement of persons with mental retardation or mental illness in nursing facilities when those persons did not require nursing services. *See Rolland*, 318 F.3d at 46.

Only after focusing on the language of § 1396r and legislative history did the panel majority turn to what it deemed the "structural elements" of the Medicaid Act. *Id.* at 23a. In doing so, the majority explained that it

> recognize[d] that provisions within the Medicaid Act speak in terms of an "agreement between Congress and a particular state." *See Sabree*, 367 F.3d at 191. Other provisions, 42 U.S.C. § 1396[c] for example, empower the Secretary of Housing [*sic*] and Human Services to suspend payments to a state if it fails to "comply substantially" with the title's requirements. These provisions gave us pause in *Sabree*, and they continue to cause us some reticence today. . . . *Sabree* counsels, however, that we must consider the existence of rights-creating language in other relevant statutory provisions of [the Medicaid Act].

Id. According to the panel majority, *Sabree* "created a test whereby courts should balance the strength of the specific language of the statutory provisions at issue against the larger structural elements of the statute." *Id.* at 24a. In applying this test, the panel majority held that the "larger statutory structure" of the Medicaid Act did not "neutralize" the rights-creating language contained within § 1396r. *Id.*

The panel majority concluded its opinion with a terse rejection of the Kane Center's argument that FNHRA's enforcement scheme was sufficiently comprehensive so as to demonstrate congressional intent

to preclude the remedy of § 1983 suits. According to the panel majority, the Kane Center had "failed to demonstrate that Congress foreclosed [the § 1983] option by adopting another, more comprehensive enforcement scheme." *Id.* at 24a. In so holding, the panel majority made no mention of FNHRA's detailed survey-and-certification system whereby Medicaid-participating nursing facilities may continue to receive Medicaid reimbursement so long as they are in substantial compliance with the Medicaid Act's requirements, nor did the panel majority make any mention of the remedial discretion afforded CMS and participating States under FNHRA's administrative enforcement scheme.

b. Senior District Judge William Stafford, Jr., sitting by designation from the United States District Court for the Northern District of Florida, dissented. App., *infra*, 25a-28a. Judge Stafford found that "federal courts have consistently held that no implied private right of action exists under the Medicaid Act, OBRA, or FNHRA." *Id.* at 26a n.6 (citing *Prince v. Dicker*, 29 F. App'x 52 (2d Cir. 2002); *Brogdon*, 103 F. Supp. 2d at 1330-32; and *Sparr*, 2002 WL 1608243, at *2-3). The Medicaid Act is Spending Clause legislation, Judge Stafford explained, and Spending Clause legislation "rarely confers upon funding beneficiaries the right to bring private actions 'before thousands of federal- and state-court judges' against funding recipients." *Id.* at 25a (quoting *Gonzaga*, 536 U.S. at 290). According to Judge Stafford:

> The Supreme Court has been explicit: "[U]nless Congress 'speak[s] with a clear voice,' and manifests an 'unambiguous' intent to confer individual rights, federal funding provisions provide no basis

> for private enforcement by § 1983." *Gonzaga*, 536 U.S. at 280 (quoting *Pennhurst State Sch. and Hosp. v. Halderman*, 451 U.S. 1, 17). In section 1396r, Congress did not speak with a "clear voice" or manifest an "unambiguous intent" to provide a basis for private enforcement of funding requirements under section 1983.

Id. at 25a-26a.

Judge Stafford paid particular attention to the Medicaid Act's supposed "structural elements," which had been relegated to the end of the panel majority's opinion:

> Under the Medicaid Act, the federal government directs funding to states to assist them in providing medical assistance to certain eligible individuals. To receive federal funds under the Medicaid Act, states are required to administer low-income medical assistance programs pursuant to "State plans" approved by the Secretary of Health and Human Services. The Act sets forth detailed requirements for state plans. Among many other things, the Act provides that "[a] State plan for medical assistance must . . . provide . . . that any nursing facility receiving payments under such plan must satisfy all the requirements of subsections (b) through (d) of section 1396r." 42 U.S.C. 1396a(a)(28)(A). Section 1396r lists the requirements that nursing facilities—as recipients of federal funding—must meet relating to the provision of services to its Medicaid patients. Importantly, in each of the provisions in subsections (b) through (d), namely, subsections (b)(1)-(8), (c)(1)-(8) and (d)(1)-(4), Congress began by stating: "The nursing facility must . . . " In each case, the focus

> is on what the nursing facility must do in return for federal funds; the focus is not on the individuals to whom the benefit of each provision flows.

Id. at 27a-28a (ellipses supplied by Judge Stafford).

Judge Stafford concluded his dissenting opinion by explaining that, "[w]hatever *Sabree* may say as to section 1396a [the provision of the Medicaid Act listing the required contents of state plans], I do not agree that Congress intended to confer upon nursing home residents the right to invoke section 1983 to sue individual nursing homes for alleged violations of" the provisions of § 1396r cited by Ms. Grammer's complaint. *Id.* at 28a.

6. The Third Circuit denied the Kane Center's petition for panel rehearing, and a majority of the circuit judges in regular active service did not vote in favor of granting en banc rehearing. App., *infra*, 47a-48a. Judge Stafford would have granted panel rehearing. *Id.* at 48a.

REASONS FOR GRANTING THE PETITION

This case provides an opportunity to resolve an important question in which several members of this Court have expressed interest: namely, whether Spending Clause legislation establishing requirements for federal-state cooperative programs can confer "rights" enforceable by third-party beneficiaries under § 1983. The Medicaid Act is prototypical Spending Clause legislation, and its provisions have spawned extensive litigation throughout the United States. However, if Spending Clause legislation cannot unambiguously confer "rights" enforceable via § 1983 in the absence of an express private right of action, such litigation unnecessarily burdens the treasuries of state and local governments, as well as

the judiciary. The time is ripe for the Court to decide this important question of federal law.

Plenary review by this Court is also warranted because, as reflected by the splintered decision below, *Gonzaga* has not had the intended effect of clarifying when one may bring a § 1983 suit based on a federal funding statute. Commentators have acknowledged that post-*Gonzaga* confusion is most pronounced in the Medicaid Act arena, where courts have been asked to parse the statute on a line-by-line basis in order to determine whether "rights" have been created. The substantial confusion that now exists breeds an enormous amount of unnecessary litigation. This Court's review is therefore warranted to bring uniformity to an important area of federal law that substantially impacts States, local governments and private litigants.

Finally, the question whether FNHRA creates individually enforceable "rights" is independently worthy of plenary review. The lower court's ruling effectively federalizes the traditionally state-law realm of medical malpractice as it relates to nursing facilities. Counsel for Ms. Grammer admitted as much during oral argument in the court of appeals, and the impact of the Third Circuit's ruling reaches far beyond § 1983 actions as plaintiffs continue to use FNHRA in arguing that the statute creates a national standard of care for governmental and nongovernmental facilities alike.

I. This Case Provides An Excellent Vehicle To Resolve The Spending Clause Question Identified By Several Members Of This Court

In *Maine v. Thiboutot*, 448 U.S. 1 (1980), a majority of the Court held that § 1983's use of the phrase

"and laws" includes claims based on violations of federal statutes other than statutes providing for equal rights. *See id.* at 4. *But see id.* at 15 (Powell, J., dissenting, joined by Burger, C.J., and Rehnquist, J.) (tracing § 1983's historical origins to § 1 of the Civil Rights Act of 1871 and concluding that the phrase "and laws," which was added to the statute during its 1874 codification in the Revised Statutes, is properly understood to only include equal rights legislation). Even after *Thiboutot*, however, a "plaintiff must assert the violation of a federal *right*, not merely a violation of federal *law*." *Blessing*, 520 U.S. at 340 (citing *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 106 (1989)).

Over the past 28 years, several members of this Court have expressed skepticism as to whether Spending Clause legislation establishing requirements for federal-state cooperative programs can create "rights" enforceable by third-party beneficiaries under § 1983. In *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1, 18-20 (1981), the Court first explained that a federal statute's use of the word "rights" created no presumption of enforceability via § 1983. In an opinion authored by then-Justice Rehnquist, the Court went on to explain that, "[i]n legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State." *Id.* at 28.

Sixteen years later, Justice Scalia, joined by Justice Kennedy, issued a concurring opinion that expressed a willingness to decide the Spending Clause

question presented by this case. *See Blessing*, 520 U.S. at 349 (Scalia, J., concurring). State-federal cooperative programs, Justice Scalia explained, are in the nature of a contract, under which the State

> promises to provide certain services to private individuals, in exchange for which the Federal Government promises to give the State funds. In contract law, when such an arrangement is made (A promises to pay B money, in exchange for which B promises to provide services to C), the person who receives the benefit of the exchange of promises between the two others (C) is called a third-party beneficiary. Until relatively recent times, the third-party beneficiary was generally regarded as a stranger to the contract, and could not sue upon it; that is to say, if, in the example given above, B broke his promise and did not provide services to C, the only person who could enforce the promise in court was the other party to the contract, A. See 1 W. Story, A Treatise on the Law of Contracts 549-550 (4th ed. 1856). This appears to have been the law at the time § 1983 was enacted. . . . If so, the ability of persons in respondents' situation to compel a State to make good on its promise to the Federal Government was not a "righ[t] . . . secured by the . . . laws" under § 1983.

Id. at 349-50 (brackets supplied by Justice Scalia).

"While it is of course true that newly enacted laws are automatically embraced within § 1983," Justice Scalia explained that it "does not follow that the question of what rights those new laws (or, for that matter, old laws) secure is to be determined according to modern notions rather than according to the

understanding of § 1983 when it was enacted. Allowing third-party beneficiaries of commitments to the Federal Government to sue is certainly a vast expansion." *Id.* at 350. Although Justice Scalia acknowledged that previous decisions of the Court had "permitted beneficiaries of federal-state contracts to sue under § 1983," the contract-based argument had not been raised in proceedings before the Court. Therefore, Justice Scalia expressed a willingness to decide the Spending Clause issue were it presented in a future case. *Id.*; *see also Golden State Transit Corp.*, 493 U.S. at 117 (Kennedy, J., dissenting) ("Our cases in recent years have expanded the scope of § 1983 beyond that contemplated by the sponsor of the statute and have identified interests secured by various statutory provisions as well.").

Justice Thomas expressed similar skepticism several years later in *Pharmaceutical Research & Manufacturers of America v. Walsh*, 538 U.S. 644 (2003). Like this case, *Walsh* raised questions related to the provision of the Medicaid Act that specifies the contents of state plans, 42 U.S.C. § 1396a. In his opinion concurring in the Court's judgment, Justice Thomas explained that the contract analogy articulated in *Pennhurst* raised "serious questions as to whether third parties may sue to enforce Spending Clause legislation." *Walsh*, 538 U.S. at 683 (Thomas, J., concurring in judgment). According to Justice Thomas:

> In contract law, a third party to the contract (as petitioner is here) may only sue for breach if he is the "intended beneficiary" of the contract. See, *e.g.*, Restatement (Second) of Contracts § 304 (1979) ("A promise in a contract creates a duty in

> the promisor to any intended beneficiary to perform the promise, and the intended beneficiary may enforce the duty"). When Congress wishes to allow private parties to sue to enforce federal law, it must clearly express this intent. Under this Court's precedents, private parties may employ 42 U.S.C. § 1983 or an implied private right of action only if they demonstrate an "unambiguously conferred right." *Gonzaga Univ. v. Doe*, 536 U.S. 273, 283 (2002). Petitioner quite obviously cannot satisfy this requirement . . . .

Id. at 683.

The state respondents in *Walsh* had not advanced the contract-based argument in proceedings before the Court. "[W]ere the issue to be raised," however, Justice Thomas explained that he would "give careful consideration to whether Spending Clause legislation can be enforced by third parties in the absence of a private right of action." *Id.*

Justice Scalia also used *Walsh* as an opportunity to reiterate the views expressed in his *Blessing* concurrence, explaining that he would "reject petitioner's statutory claim on the ground that the remedy for the State's failure to comply with the obligations it has agreed to undertake under the Medicaid Act . . . is set forth in the Act itself: termination of funding by the Secretary of the Department of Health and Human Services, see 42 U.S.C. § 1396c." *Id.* at 675 (Scalia, J., concurring in judgment).

Finally, in the very decision on which the Third Circuit based much of its ruling below, then-Judge Alito used language suggesting a willingness to address the Spending Clause question presented by this case. In *Sabree*, the district court had looked to

the Medicaid Act's origin as Spending Clause legislation in finding that it did not unambiguously confer federal "rights" enforceable by Medicaid beneficiaries. *See Sabree ex rel. Sabree v. Houston*, 245 F. Supp. 2d 653, 659-70 (E.D. Pa. 2003). In concurring with the Third Circuit opinion reversing the district court, Judge Alito explained that, "[w]hile the analysis and decision of the District Court *may reflect the direction that future Supreme Court cases in this area will take*, currently binding precedent supports the decision of the Court." *Sabree*, 367 F.3d at 194 (Alito, J., concurring) (emphasis added); *see also Arlington Cent. Sch. Dist. v. Murphy*, 548 U.S. 291, 296 (2006) (Alito, J.) (discussing *Pennhurst*'s contract analogy for Spending Clause legislation in finding that the Individuals with Disabilities Education Act did not contain unambiguous language putting States on notice that, as a condition of accepting federal funds, States could be ordered to pay expert-witness fees).

If, in the final analysis, Spending Clause legislation cannot create "rights" enforceable via § 1983 in the absence of an express private right of action, a substantial portion of the § 1983 litigation in the United States unnecessarily burdens state and local treasuries, state and local officials, and the judiciary. This important question of federal law deserves a definitive answer. This case affords the Court with the opportunity to provide that answer.

II. Review Is Warranted To Fully Achieve *Gonzaga*'s Goal Of Clarifying This Court's § 1983 Jurisprudence

By granting review in *Gonzaga*, the Court hoped to "resolve any ambiguity" in the Court's § 1983

jurisprudence. 536 U.S. at 278. As reflected by the Third Circuit's splintered decision below and the numerous divergent opinions issued by other lower courts since *Gonzaga* was decided, that important goal has not been—but should be—fully realized.

Nowhere is post-*Gonzaga* confusion more pronounced than with respect to the Medicaid Act, the provisions of which have spawned extensive § 1983 litigation throughout the United States. As described by a recent analysis prepared by the National Health Law Program, since the year in which *Gonzaga* was decided (2002), federal appellate courts have been asked to review the enforceability of at least 14 different Medicaid Act subsections in 25 different appellate rulings. *See* Jane Perkins, National Health Law Program, *Developments Affecting Medicaid Cases Filed Under 42 U.S.C. § 1983* at 6 (Dec. 31, 2008).[1]

The result has been a patchwork of rulings finding that certain subsections within the Medicaid Act create individually enforceable "rights" while others do not. *Compare, e.g.*, *Pediatric Specialty Care, Inc. v. Selig*, 443 F.3d 1005, 1015 (8th Cir. 2006) (holding that provisions of § 1396a create "rights" enforceable under § 1983), *vacated as moot*, 551 U.S. 1142 (2007) (No. 06-415); *Westside Mothers v. Olszewski*, 454 F.3d 532, 544 (6th Cir. 2006) (same), *with Hobbs ex rel. Hobbs v. Zenderman*, 579 F.3d 1171, 1175 (10th Cir. 2009) (holding that provisions of § 1396a do not create "rights" enforceable under § 1983); *Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697,

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[1] Http://www.healthlaw.org/library/attachment.139385.

704 (5th Cir. 2007) (same), *cert. denied*, 129 S. Ct. 34 (2008) (No. 07-1160); *Okla. Chapter of the Am. Acad. of Pediatrics v. Fogarty*, 472 F.3d 1208, 1210 (10th Cir. 2007) (same), *cert. denied*, 552 U.S. 813 (2007) (No. 06-1482); *N.Y. Ass'n of Homes & Servs. for the Aging, Inc. v. DeBuono*, 444 F.3d 147 (2d Cir. 2006) (per curiam) (same); *Sanchez v. Johnson*, 416 F.3d 1051, 1062 (9th Cir. 2005) (same).

As one commentator recently concluded in analyzing the current state of § 1983 jurisprudence in the Medicaid Act arena: "Federal circuit and district courts have inconsistently and confusingly applied the *Gonzaga* framework, which was supposed to clarify private causes of action under § 1983." Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. Davis L. Rev. 413, 415 (2008) (footnote omitted). "*Gonzaga*'s legacy is a hodgepodge of lower court decisions. Some courts have substituted *Gonzaga* for the first element of the *Blessing* test, some courts primarily have substituted *Gonzaga* for, or conflate, *Gonzaga* and *Blessing*, and some courts effectively ignore *Gonzaga*." *Id.* at 442-43 (footnotes omitted). "Federal courts," Professor Huberfeld concludes, "have read some provisions [of the Medicaid Act] to be enforceable by enrollees, some provisions to be enforceable by providers, and some provisions to be enforceable by no one. Though the statutory framework is long and complex, inconsistent and variable enforcement possibilities can only confound the problem." *Id.* at 452; *see also* Comment, *Section 1983 Enforcement of the Medicaid Act After Gonzaga University v. Doe: The 'Dispassionate Lens' Examined*, 74 U. Chi. L. Rev. 991 (2007) (concluding that "circuit splits have developed regarding the proper scope of

the textual analysis commanded by *Gonzaga* and, derivatively, regarding the § 1983 enforceability of some of the Medicaid Act's most notable statutory provisions").

Accordingly, plenary review is warranted to fully achieve *Gonzaga*'s goal of clarifying this Court's § 1983 jurisprudence.

III. The Second Question Presented Is Independently Worthy Of Plenary Review Because The Lower Court's Ruling Effectively Federalizes The Traditionally State-Law Realm Of Medical Malpractice As It Relates To Nursing Facilities

In finding that the educational privacy legislation at issue in *Gonzaga* did not unambiguously confer "rights" upon individuals that were enforceable under § 1983, the Court highlighted the fact that education was an area in which Congress had traditionally deferred to state and local officials. *See* 536 U.S. at 286 n.5. As such, the Court believed it highly unlikely that Congress sought to intervene in a traditional state and local function by subjecting school officials to "private suits for money damages whenever they fail to comply with a federal funding condition." *Id.*

Similar considerations are present in this case, as the Third Circuit's ruling effectively federalizes medical malpractice as it relates to nursing facilities. This Court has long recognized that the field of medical malpractice is one traditionally governed by state law. *See, e.g.*, *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 387 (2002) (describing "reasonable medical care" as involving "quintessentially state-law standards"); *Pegram v. Herdrich*, 530 U.S.

211, 237 (2000) (noting that the "field of health care" is "a subject of traditional state regulation"). However, during the following colloquy between Circuit Judge Smith and counsel for Ms. Grammer, counsel acknowledged that the theory of Ms. Grammer's case would have profound consequences if judicially accepted:

> Q. Let me begin by asking you what I suppose could be construed as a question of legal policy. But is not the position that you urge upon us one that would completely federalize malpractice cases that occur in nursing homes that are operated by state and local governments?
>
> A. To some extent, yes.
>
> Q. Well, to what extent would it not?
>
> A. To the extent that those nursing homes did not participate in the Medicaid program. But once they choose to participate in the federal Medicaid program, then they are bound to [abide] by the Medicaid regulations.

Oral Arg. Recording at 00:01:43-00:02:30, *Grammer v. John J. Kane Reg'l Ctrs. - Glen Hazel*, No. 07-2358 (3d Cir. May 20, 2008).[2]

It would be highly unusual if a government-operated nursing facility did *not* participate in Medicaid, which is by far the single largest funding source for nursing facility services. *See, e.g.*, U.S. Gen. Accounting Office, *Medicaid Nursing Home Pay-*

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[2] Http://www.ca3.uscourts.gov/oralargument/audio/07-2358GrammervKaneRegionalCenters.wma.

ments at 1, Rep. No. GAO-04-143 (2003) (explaining that Medicaid "pays at least in part for the care provided to approximately two in three nursing home residents"). Government-operated nursing facilities such as the Kane Center are typically tasked with serving individuals with low incomes or disabilities, which are the very populations targeted by Medicaid. As such, the practical effect of the ruling below is to federalize the field of medical malpractice as it relates to government-operated nursing facilities, many of which have been granted immunity from medical malpractice liability by their respective state legislatures. *See, e.g.*, *Davis v. County of Westmoreland*, 844 A.2d 54, 56 (Pa. Commw. Ct. 2004) (explaining that under Pennsylvania statutory law, county-owned nursing facilities such as the Kane Center are granted immunity to malpractice liability). This is especially true when one remembers that, by filing suit under § 1983 instead of using traditional common-law remedies, plaintiffs will be able to seek attorney's fees under 42 U.S.C. § 1988, as Ms. Grammer does in this case.

The ramifications of the Third Circuit's ruling go beyond just government-operated nursing facilities, however. As counsel for Ms. Grammer admitted during oral argument in the court below, even in cases involving nongovernmental nursing facilities, plaintiffs regularly use FNHRA in arguing that the statute creates a national standard of care or that it may serve as the basis for a negligence *per se* claim. *See* Oral Arg. Recording at 00:13:15-00:13:35 ("As we routinely do in a situation like this where the defendant-home is a Medicaid beneficiary, we rely upon the violations of these federal provisions in the Medicaid Act to serve as a basis for, not only the standard

of care, . . . but also negligence *per se* for their violation."). In finding that FNHRA unambiguously confers federal "rights" on individual Medicaid beneficiaries, the Third Circuit's ruling lends significant credence to this questionable, yet pervasive, practice.

That courts overwhelmingly have refused to find an implied right of action within FNHRA also counsels that the panel majority's decision is incorrect. *Gonzaga* held that a "court's role in discerning whether personal rights exist in the § 1983 context should . . . not differ from its role in discerning whether personal rights exist in the implied right of action context." 536 U.S. at 285. As clearly explained by both the district court and the Third Circuit dissent in this case, courts have regularly held that FNHRA does not create an implied right of action. App., *infra*, 26a n.6, 37a-38a (collecting cases); *see also Johnson v. Badger Acquisition of Tampa, LLC*, 983 So. 2d 1175, 1182 (Fla. Dist. Ct. App. 2008) ("Interpreting [FNHRA] to create a legal duty in this context would invite an unusual federal encroachment into Florida common law in an area typically a subject of state regulation."). Therefore, the panel majority's decision conflicts with the weight of existing authority—existing authority that the panel majority made no attempt to distinguish.

CONCLUSION

For the foregoing reasons, the Court should grant the petition for a writ of certiorari and reverse the judgment of the court of appeals. Alternatively, the

Court may wish to invite the Solicitor General to file a brief expressing the views of the United States.[3]

Respectfully submitted.

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[3] The Court invited the Solicitor General to file such a brief in *Selig v. Pediatric Specialty Care, Inc.*, 549 U.S. 1202 (2007) (No. 06-415), which asked whether certain provisions of the Medicaid Act create federal "rights" that are privately enforceable under § 1983. However, the plaintiff-respondents acted to moot the case prior to such a brief being filed. *See Selig v. Pediatric Specialty Care, Inc.*, 551 U.S. 1142 (2007) (granting the petition for a writ of certiorari, vacating the lower court's judgment, and remanding the case with instructions for the lower court to dismiss the appeal as moot) (citing *United States v. Munsingwear, Inc.*, 340 U.S. 36 (1950)); *see also* Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. Davis L. Rev. 413, 450 (2008) (explaining that the plaintiff-respondents in *Selig* acted to moot the case after meeting with the Office of the Solicitor General).

APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 07-2358

SARAH GRAMMER, as Administratrix of the Estate of Melvinteen Daniels, Deceased,

Appellant

v.

JOHN J. KANE REGIONAL CENTERS - GLEN HAZEL

On Appeal from the United States District Court for the Western District of Pennsylvania

(D.C. No. 06-cv-00781)

District Judge: The Honorable Gary L. Lancaster

ARGUED MAY 20, 2008

BEFORE: SMITH and NYGAARD, *Circuit Judges*, and STAFFORD,* *District Judge*.

* Honorable William H. Stafford, Jr., Senior District Judge for the United States District Court for the Northern District of Florida, sitting by designation.

(Filed on June 30, 2009)

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OPINION OF THE COURT

NYGAARD, *Circuit Judge*.

We are asked in this appeal to determine whether an action will lie under 42 U.S.C. § 1983 to challenge the treatment Appellant's decedent received (or did not receive) at the Appellee nursing home – treatment Appellant argues violated the Federal Nursing Home Reform Amendments (FNRA), 42 U.S.C. § 1396r et seq. We answer that question in the affirmative and will reverse and remand the cause to the District Court.

In so holding, we conclude that the language of the FNHRA is sufficiently rights-creating and that

the rights conferred by its various provisions are neither "vague and amorphous" nor impose upon states a mere precatory obligation. *See Gonzaga Univ. v. Doe*, 536 U.S. 273, 287 (2002) (citing *Alexander v. Sandoval*, 532 U.S. 275-288-89 (2001)). Further, we conclude that § 1983 provides the proper avenue for relief because the Appellee has failed to demonstrate that Congress foreclosed that option by adopting another, more comprehensive enforcement scheme. *See Gonzaga Univ.*, 536 U.S. at 284.

I.

Appellant's mother, Melviteen Daniels, was a resident of the John J. Kane Regional Center at Glen Hazel, in Pittsburgh, Pennsylvania. The Kane Center is a residential skilled nursing care and rehabilitation center for short-term and/or long-term needs, and is operated by Allegheny County. The Appellant maintains that, as a result of Kane Center's failure to provide proper care, her mother developed decubitus ulcers, became malnourished and eventually developed sepsis, from which she died.

Grammer sued Kane Center bringing claims under 42 U.S.C. § 1983 for wrongful death (Count I) and survival (Count II). Grammer alleged that the Kane Center deprived Mrs. Daniels of her civil rights by breaching a duty to ensure quality care under the Omnibus Budget Reconciliation Act of 1987 (OBRA) and, more specifically, the FNHRA thereto. The Kane Center filed a motion to dismiss, arguing that neither the OBRA nor the FNHRA provide a right that is enforceable through § 1983. The Kane Center maintained that the statutes merely set forth re-

quirements a nursing facility must comply with to receive federal Medicaid funds. The District Court adopted the Magistrate Judge's recommendation finding no right of action under the statutes, and dismissed the case pursuant to Fed. R. Civ. P. 12(b)(6).

II.

Our jurisdiction is found in 28 U.S.C. § 1291 which gives us jurisdiction over final decisions of the district courts. When deciding a motion under Federal Rule of Civil Procedure 12(b)(6), a district court must "accept all factual allegations as true, construe the complaint in the light most favorable to the plaintiff, and determine whether, under any reasonable reading of the complaint, the plaintiff may be entitled to relief." *Phillips v. County of Allegheny*, 515 F.3d 224, 233 (3d Cir. 2008). Our review of such a dismissal is plenary. *Leveto v. Lapina*, 258 F.3d 156, 161 (3d Cir. 2001).

III.

Title XIX of the Social Security Act, codified at 42 U.S.C. §§ 1396-1396v is popularly known as the "Medicaid Act." This Act established a "cooperative federal-state program under which the federal government furnishes funding to states for the purpose of providing medical assistance to eligible low-income persons." *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 182 (3d Cir. 2004) (citing *Pa. Pharm. Ass'n v. Houstoun*, 283 F.3d 531, 533 (3d Cir. 2002)). States are, of course, not required to participate in this program, but those that do accept federal funding

must comply with the Medicaid Act and with regulations promulgated by the Secretary of Health and Human Services. *Id.*

Before Congress amended the Medicare and Medicaid Acts in 1987, only two sanctions were available against nursing homes for noncompliance with federal participation requirements. First, the Secretary of Health and Human Services or the states themselves could decertify the facility and terminate the nursing home's eligibility to receive Medicaid reimbursements. Second, if noncompliance was not an immediate and serious threat to the residents' health and safety, the Secretary or the states could deny payment for new admissions for up to eleven months. These sanctions were rarely invoked. As a result, the programs permitted too many substandard nursing homes to continue operations. Congress thus became "deeply troubled that the Federal Government, through the Medicaid program, continue[d] to pay nursing facilities for providing poor quality care to vulnerable elderly and disabled beneficiaries." H.R. Rep. No. 100-3901, at 471 (1987), reprinted in 1987 U.S.C.C.A.N. 2313-1, 2313-272.

In 1987, Congress passed the FNHRA, contained in OBRA, to provide for the oversight and inspection of nursing homes that participate in Medicare and Medicaid programs.[1] The requirements for certifica-

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[1] This federal legislation comes by its common name "OBRA" through the legislative process. Congress, then and now, usually completes a huge measure of its budgetary and substantive work in one large bill. The bill accomplishing that function in 1987 was entitled the Omnibus Budget Reconcilia-

(continued)

tion include satisfying certain standards in areas such as "quality of care" and "resident rights." 42 U.S.C. §§ 1395i-3(g), 1396r(g).

Grammer's complaint alleged claims under § 1983 for wrongful death (Count I) and survival (Count II). Grammer contends that the Kane Center's failure to provide the standards of care delineated by the FNHRA deprived her mother of her civil rights. Grammer's complaint focuses on the following provisions of the FNHRA:

- A nursing home must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident, 42 U.S.C. § 1396r(b)(1)(A);
- A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident in accordance with a written plan of care which (a) describes the medical, nursing and psychosocial needs of the resident and how such needs will be met; 42 U.S.C. § 1396r(b)(2)(A);

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tion Act of 1987 or "OBRA '87." The separate Federal Nursing Home Reform Act together with many other separate bills were "rolled into" one bill to insure final passage of all the elements. Some courts have referred to the statutory provisions at issue herein as the Federal Nursing Home Reform "Act." *See e.g. Blue v. Koren*, 72 F.3d 1018 (2d Cir. 1995). Other courts refer to these provisions collectively as the Federal Nursing Home Reform "Amendments." *See e.g. Grant ex rel. Family Eldercare v. Gilbert*, 324 F.3d 383 (5th Cir. 2003). We find the designation "amendments" a more accurate reflection of the legislative history.

- A nursing facility must conduct a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity, which assessment (i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity; (iv) including identification of medical problems; 42 U.S.C. § 1396r(b)(3)(A);
- To the extent needed to fulfill all plans of care described in paragraph (2), a nursing facility must provide (or arrange the provision of) dietary services that assure the meals meet the daily nutritional and special dietary needs of each resident. Services described in clause (iv) must be provided by qualified persons in accordance with each resident's written plan of care; 42 U.S.C. § 1396r(b)(4)(A)(iv);
- A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident in accordance with a written plan of care which (C) is periodically reviewed and revised after each assessment under paragraph (3) — such assessment must be conducted (i) promptly upon (but not later than 14 days after the date of) admission for each individual admitted on or after October 1, 1990; (ii) the nursing facility must examine each resident no less frequently than once every three months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment; (D) the results of such an assessment shall be used in developing, reviewing and revising the resident's plan of care under paragraph (2); 42

U.S.C. § 1396r(b)(2)(C), (b)(3)(C)(i)(I) & (ii), (b)(3)(D), (b)(4)(B);

- To the extent needed to fulfill all plans of care described in paragraph (2), a nursing facility must provide (or arrange the provision of) (ii) medically related services to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident; (v) an ongoing program, directed by qualified professional, of activities designed to meet the interests and the physical, mental and psychosocial well-being of each resident; 42 U.S.C. § 1396r(b)(4)(A)(ii) & (v);
- A nursing facility must maintain clinical records on all residents, which records include the plans of care (described in paragraph (2)) and the residents' assessments (described in paragraph (3)), as well as the results of any preadmission screening conducted under subsection (e)(7) of this section; 42 U.S.C. § 1396r(b)(6)(C);
- The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms, (D) Psycho-pharmacologic drugs may be administered only on the orders of a physician and only as part of a plan designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually an independent, external consultant reviewed the appropriateness of the drug plan of each resident receiving such drugs; 42 U.S.C. § 1396r(c)(1)(A)(ii) & (c)(1)(D).

We are therefore presented with the question whether these various provisions of the FNHRA[2] give Medicaid recipients like Melviteen Daniels rights whose violation can be remedied under § 1983. As noted, we answer in the affirmative.

IV.

A.

42 U.S.C. § 1983 is a vehicle for imposing liability against anyone who, under color of state law, deprives a person of "rights, privileges, or immunities secured by the Constitution and laws." *Maine v. Thiboutot*, 448 U.S. 1, 4-6 (1980); *see also Three Rivers Center for Independent Living v. Housing*

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[2] Residents of nursing homes cannot directly sue to enforce compliance with federal standards. The statutes at issue in this case do not expressly authorize private causes of action to enforce their provisions and the parties do not dispute this. Federal laws that do not explicitly authorize private causes of action may do so implicitly. Furthermore, actions for violations of federal law under 42 U.S.C. § 1983 are "presumptively available" against individuals acting under color of state law. *Livadas v. Bradshaw*, 512 U.S. 107, 133 (1994). As we have indicated, "the distinction between implied private rights of action and § 1983 private rights of action rests not in the articulation of rights, but in the availability of a remedy." *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 188 n.17 (citing *Gonzaga Univ.*, 536 U.S. at 285). Further, "we take it as a given that when seeking redress under § 1983 for violation of a statutory right, a plaintiff need not establish that Congress intended to confer a remedy in addition to that right." *Id.* at 183 n.7. Section 1983 itself provides the remedy. *See e.g.*, *Gonzaga Univ.*, 536 U.S. at 284.

Authority of City of Pittsburgh, 382 F.3d 412, 421-22 (3d Cir. 2004). However, a plaintiff must assert the violation of a federal right — not merely a violation of a federal law — to seek redress. *See Blessing*, 520 U.S. at 340; *Golden State Transit Corp. v. Los Angeles*, 493 U.S. 103, 106 (1989). If a plaintiff alleges a violation of a federal right as the basis of a § 1983 action, we must determine whether the applicable federal statute confers an individual right. *Blessing*, 520 U.S. at 340. That is to say, whether a particular federal statute creates a federal right of the kind enforceable by an action for damages under § 1983 requires that we determine "whether or not Congress intended to confer individual rights upon a class of beneficiaries." *Gonzaga Univ.*, 536 U.S. at 285. A plaintiff bears the burden of establishing that a statute gives rise to federal rights enforceable through § 1983. *Blessing*, 520 U.S. 342, 346; *City of Rancho Palos Verdes, California v. Abrams*, 544 U.S. 113, 120 (2005).

B.

In *Blessing*, the Supreme Court set forth three factors courts should use to determine whether a statute conferred a federal right upon an individual: first, courts should determine whether Congress intended that the statutory provision in question benefits the plaintiff; second, courts should decide whether the right asserted is so "vague and amorphous" that its enforcement would strain judicial competence; and lastly, courts should determine whether the statute unambiguously imposes a binding obligation on the states. 520 U.S. at 340-41. The Supreme Court further instructed that if a plaintiff

successfully meets these three requirements, she has established a rebuttable presumption that she has such a right. However, this presumption could be rebutted if Congress "specifically foreclosed a remedy under § 1983." *Gonzaga Univ.*, 536 U.S. at 341.

Although the *Blessing* analysis may appear straightforward, subsequent Supreme Court decisions have suggested that there are fine distinctions in its application, requiring us to look not only at the statutory text, but also to congressional intent. In *Gonzaga Univ.*, the Supreme Court applied the *Blessing* test, but noted that there had been some confusion in that test's interpretation. *Id.* at 283. The Supreme Court noted that *Blessing* had come to mean that a plaintiff could enforce a statute under § 1983 "so long as the plaintiff falls within the general zone of interest that the statute is intended to protect, something less than what is required for a statute to create rights enforceable directly from the statute itself under an implied private right of action." *Id.* The Supreme Court clarified the *Blessing* analysis, stating that "we now reject the notion that our cases permit anything short of an unambiguously conferred right to support a cause of action under § 1983." *Id.* Further the Supreme Court outright "reject[ed] the notion that our implied right of action cases are separate and distinct from our § 1983 cases." *Id.* The Supreme Court advised that when determining whether a right of action is implied in a particular statutory provision, we should be guided by "the determination of whether a statute confers rights enforceable under § 1983." *Id.* Thus, *Gonzaga Univ.* clarified the *Blessing* analysis by adding the requirement that any such right be unambiguously conferred by Congress.

We applied the *Blessing* analysis, as redefined by *Gonzaga Univ.*, in *Sabree*, *supra*. We recently reviewed our *Sabree* decision in *Newark Parents Assoc. et al. v. Newark Pub. Schl.*, 547 F.3d 199 (3d Cir. 2008), and will briefly summarize *Sabree* again here because it is the foundation for our holding in this appeal.

In *Sabree*, we were asked to decide whether a provision of the Medicaid statute that required states to provide medical services from an intermediate care facility "with reasonable promptness" to developmentally disabled persons, unambiguously conferred private rights upon them.

We first determined the characteristics of an unambiguously conferred right. We held that to confer such a right, *Gonzaga Univ.* required a statute to contain rights-creating language which clearly imparts an individual entitlement with an "unmistakable focus on the benefited class." *Sabree*, 367 F.3d at 187 (quoting *Blessing*, 520 U.S. at 343 and *Gonzaga Univ.*, 536 U.S. at 287). By way of example, we noted in *Sabree* that the Medicaid Act required that a "state plan for medical assistance . . . must provide medical assistance . . . to . . . all [eligible] individuals" and that "such assistance shall be furnished with reasonable promptness to all eligible individuals." *Id.* at 182, n.4, 189. We concluded that the statutory language requiring that a state "must provide" medical services with reasonable promptness met all three factors of the *Blessing* analysis because the plaintiffs were the intended beneficiaries of the statute, the rights the plaintiffs sought to enforce were specific and enumerated and that the

obligation imposed upon the states was unambiguous and binding. *Id.* at 189.

Although the plaintiffs in *Sabree* satisfied the *Blessing* test, we examined the statutes further to ensure that the unambiguous rights asserted were conferred upon the plaintiffs, and not that the plaintiffs merely fell within a "general zone of interest that the statute is intended to protect." *Id.* at 189-90. We noted that the statutory requirement that a plan "must provide" services was analogous to the "no person shall" language determined by the Supreme Court in *Gonzaga Univ.* to be an example of rights-creating language. Additionally, we determined that the statutory language was "mandatory rather than precatory." *Id.* at 190. Finally, we noted that the relevant provisions provided that such entitlements be made available to "all eligible individuals" and, as such, did not focus on the "entity regulated rather than the individuals protected." *Id.* We therefore concluded that the plain meaning of the statutory text clearly delineated rights that were both unambiguous and personal in nature, such that personal rights were indeed intended by Congress.[3]

As we see it, the Supreme Court's decision in *Gonzaga Univ.*, as interpreted by our own opinions in *Sabree* and *Newark Parents Assoc.* require us to first

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[3] The Courts of Appeal for the First, Fourth, Fifth and Ninth Circuits have all held that the same Medicaid provisions we considered in *Sabree* confer individual rights. *Bryson v. Shumway*, 308 F.3d 79, 88-89 (1st Cir. 2002); *Doe v. Kidd*, 502 F.3d 348, 356 (4th Cir. 2007); *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 603 (5th Cir. 2004); *Watson v. Weeks*, 436 F.3d 1152, 1155 (9th Cir. 2006).

apply the three components of the *Blessing* test and then, to inquire into whether the statutes in question unambiguously confer a substantive right.

C.

There is no question that the statutory provisions under which Grammer raises her claims meet the first *Blessing* factor. As both a Medicaid recipient and a nursing home resident, Grammer's mother was an intended beneficiary of 42 U.S.C. § 1396r. The Court of Appeals for the Second Circuit also has held as much. In *Concourse Rehabilitation & Nursing Center Inc. v. Whalen*, 249 F.3d 136 (2d Cir. 2001), the Court of Appeals specifically noted that Medicaid recipients were the intended beneficiaries of § 1396r. In that case, nursing homes sued the New York Department of Health, alleging violations of the Medicaid program and the FNHRA. The Court of Appeals reviewed § 1396r and determined that it did not entitle nursing homes to bring suit. Instead, the Court of Appeals held that the provisions of 42 U.S.C. § 1396r and its accompanying regulations requiring nursing facilities to "provide . . . specialized rehabilitative services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident" demonstrate clearly from the plain language of the provision that it was not "intend[ed] to benefit the putative plaintiff[s]" — the health care providers in that case. 249 F.3d at 143-44. *See also Wilder*, 496 U.S. at 509. Instead, the Court of Appeals found that the provisions were "obviously intended to benefit Medicaid beneficiaries." *Id.* at 144. We agree with this reasoning. The provisions are obviously intended to benefit Medicaid

beneficiaries and nursing home residents, not the nursing homes themselves.

Moreover, unlike the statutes at issue in *Gonzaga Univ.* and *Blessing*, the FNHRA are directly concerned with "whether the needs of any particular person have been satisfied." *Blessing*, 520 U.S. at 343, quoted in *Gonzaga Univ.*, 536 U.S. at 288. In *Blessing*, for example, the Supreme Court pointed out that the statute at issue provided a "yardstick for the Secretary to measure . . . systemwide performance" of a state program. *Id.* at 343. Here, in contrast, the FNHRA'[s] concern is whether each individual placed in a nursing home receives proper care.

The second *Blessing* factor is also met here. The rights Grammer asserts are not so "vague or amorphous" that their enforcement would strain judicial resources. The various rights are clearly delineated by the provisions at issue. The repeated use of the phrases "must provide," "must maintain" and "must conduct" are not unduly vague or amorphous such that the judiciary cannot enforce the statutory provisions. These provisions make clear that nursing homes must provide a basic level of service and care for residents and Medicaid patients.

Finally, the language unambiguously binds the states and the nursing homes as indicated by the repeated use of "must." This language is mandatory in nature and easily satisfies the third factor of the *Blessing* test.

D.

As we held in *Sabree*, *supra*, meeting *Blessing's* "zone of interest" factor is not enough. In *Gonzaga*

Univ., the Supreme Court cautioned us to be careful to ensure that the statute at issue contains "rights-creating language" and to make certain that the language is phrased in terms of the persons benefited, not in terms of a general "policy or practice." 536 U.S. at 287. While *Blessing* stands for the proposition that violations of rights, not laws, give rise to § 1983 actions, nevertheless, the *Gonzaga Univ.* court warned against interpreting *Blessing* "as allowing plaintiffs to enforce a statute under § 1983 so long as the plaintiff falls within the general zone of interest that the statute is intended to protect." *Gonzaga Univ.*, 536 U.S. at 283. Therefore, nothing short of an "unambiguously conferred [individual] right" as demonstrated through "rights-creating language" can support a § 1983 action. *Id.* at 283, 290.

The Supreme Court explained that rights-creating language must clearly impart an individual entitlement, and have an "unmistakable focus on the benefited class." *Id.* (quoting *Blessing*, 520 U.S. at 343; *Cannon v. Univ. of Chicago*, 441 U.S. 677, 690-93, (1979)). The Supreme Court next demonstrated the type of rights-creating terms that unambiguously confer enforceable rights by looking to its implied right of action cases. *Id.* at 283-84. To exemplify rights-creating language, the Supreme Court looked to the language of Title VI of the Civil Rights Act of 1964, stating that "No person in the United States shall . . . be subjected to discrimination under any program or activity receiving Federal financial assistance" on the basis of race, color or national origin, and Title IX of the Education Amendments of 1972, stating "No person in the United States shall, on the basis of sex . . . be subjected to discrimination

under any education program or activity receiving Federal financial assistance." *Id.* at 284 n.3 (quoting 42 U.S.C. § 2000d (emphasis added); 20 U.S.C. § 1681(a)).

Comparing the language of the statute at issue in *Gonzaga Univ.* — the Family Educational Rights and Privacy Act of 1974 (FERPA) — to the rights-creating language used in Title VI and Title IX, the Court found that FERPA's provisions, stating "no funds shall be made available" to any "educational agency or institution" which has a prohibited "policy or practice," were in stark contrast to Title VI and Title IX. *Id.* at 283.

Gonzaga Univ. found that the specific mandatory, individually focused language of Titles VI and IX confer individual rights, while the programmatic, aggregate focus of FERPA's language merely created law applicable to the states. We must, therefore, compare the language of the statutes at issue in Grammer's case, namely, 42 U.S.C. § 1396r, et seq. to Title VI, Title IX, and FERPA, to determine whether Congress used rights-creating language before proceeding to the remaining steps in the *Blessing* analysis.

In *Sabree*, we compared 42 U.S.C. §§ 1396a(a)(8), 1396a(a)(10), and 1396d(a)(15) to Title VI, Title IX and FERPA, and found that those sections of the Medicaid Act did create individually enforceable rights. Determining whether Congress used rights-creating language when drafting § 1396a(a)(8), we found that in requiring states that accept Medicaid funding to provide ICF/MR services with reasonable promptness, Congress conferred specific entitlements on individuals "in terms that could not be clearer."

367 F.3d at 190 (quoting *Gonzaga Univ.*, 536 U.S. at 280). Specifically, § 1396a(a)(8) provides, in pertinent part, "[a] State plan for medical assistance must . . . provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals." Particularly relevant to the existence of rights-creating terms in *Sabree* was our determination that the terms of the statutory provisions at issue were "mandatory rather than precatory," they had an "individual focus" on "all eligible individuals," and even though they inform the state of its compliance requirements, the terms do not focus on the "entity regulated rather than the individuals protected." *Id.* at 190.

The FNHRA are replete with rights-creating language. The amendments confer upon residents of such facilities the right to choose their personal attending physicians, to be fully informed about and to participate in care and treatment, to be free from physical or mental abuse, to voice grievances and to enjoy privacy and confidentiality. 42 U.S.C. § 1396r(c)(1)(A). Nursing homes are required to care for residents in a manner promoting quality of life, provide services and activities to maintain the highest practicable physical, mental and psychosocial well-being of residents, and conduct comprehensive assessments of their functional abilities. 42 U.S.C. § 1396r(b)(1), (2) & (3). Further, the statute specifically guarantees nursing home residents the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for the purposes of

discipline or convenience and not required to treat their medical symptoms. 42 U.S.C. § 1396r(1)(A)(ii).

As they were in *Sabree*, the provisions at issue here are mandatory. For example, by stating "a nursing home *must care* for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident," the mandatory nature of the provision is apparent. 42 U.S.C. § 1396r(b)(1)(A) (emphasis added). Another provision of the FNHRA provides that "a nursing facility *must provide* services and activities to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident." 42 U.S.C. § 1396r(b)(2)(A) (emphasis added). These provisions, as well as the others under which Grammer brought claims, are strikingly similar to those at issue in *Sabree*. In *Sabree*, we found the phrase "a state plan of medical assistance must provide," to be rights-creating. *See Sabree*, 367 F.3d at 190.

Additionally, the FNHRA use the word "residents" throughout. Thus, its provisions are clearly "phrased in terms of the persons benefited." *See Gonzaga Univ.*, 536 U.S. at 284 (quoting *Cannon*, 441 U.S. at 692 n.13). Moreover, no provision uses the word "resident" simply in passing. Instead, the FNHRA are constructed in such a way as to stress that these "residents" have explicitly identified rights, such as "the *right* to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms." 42 U.S.C. § 1396r(c)(1)(A) (emphasis

added). These statutory provisions are, in other words, "concerned with 'whether the needs of any particular person have been satisfied,'" not solely with an aggregate institutional policy and practice. *Id.* at 288 (quoting *Blessing*, 520 U.S. at 343).

We are not concerned that the provisions relied upon by the Appellant are phrased in terms of responsibilities imposed on the state or the nursing home. The plain purpose of these provisions is to protect rights afforded to individuals. *See e.g., Johnson v. Housing Auth. of Jefferson Parish*, 442 F.3d 356, 360, 363 (5th Cir. 2006) (finding a right of action by low-income families even though the provision at issue required payments be made to landlords as opposed to being made to the intended beneficiaries of the statute, low-income families). Further, the statutory provisions relied upon by the Appellant are distinguishable from the FERPA provision the Supreme Court found to be "two steps removed from the interests of individual students and parents." *Gonzaga Univ.*, 536 U.S. at 287. The FERPA provision at issue in *Gonzaga Univ.* concerned policies and practices that must be in place to obtain federal funding. In this case, the provisions under review directly impact the individual in that they determine the level of care and service an individual is to receive. The various provisions of the FNHRA at issue here place an "unmistakable focus on the benefited class — Medicaid recipients who are residents of Medicaid participating nursing homes. *See Gonzaga Univ.*, 536 U.S. at 284.

The legislative history of the enactment of the FNHRA is likewise compelling when determining Congressional intent to create a right of action. In

Rolland, 318 F.3d at 45-47, the Court of Appeals for the First Circuit examined the legislative history of the FNHRA at length, and it bears repeating here:

> In 1987, Congress passed the NHRA, part of the Omnibus Budget Reconciliation Act, as a response to th[e] apparently widespread problem [of mentally ill and mentally retarded individuals being placed in nursing homes that were unable to provide the necessary and appropriate services and treatments]. The report from the House of Representatives began:
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> "Substantial numbers of mentally retarded and mentally ill residents are inappropriately placed, at Medicaid expense, in [skilled nursing facilities] or [intermediate care facilities]. These residents often do not receive the active treatment or services that they need. A recent [Government Accounting Office] review of mentally retarded residents in [these facilities] in Connecticut, Massachusetts, and Rhode Island concluded that the active treatment needs of these individuals were generally not being identified or met."
>
> The NHRA attempted to ensure that those placed in nursing homes actually needed nursing care and that once residing in a nursing home, individuals would receive the other kinds of treatment they needed. Towards that end, the NHRA established requirements for nursing homes in their care of mentally retarded [and mentally ill] residents, 42 U.S.C. § 1396r(b); instituted specific enumerated rights for residents, id. § 1396r(c); and required states to screen and provide services to mentally retarded [and mentally ill] residents, id. § 1396r(e).

Rolland, 318 F.3d at 46 (quoting H.R. Rep. No. 100-391, pt. 1, at 459, reprinted in 1987 U.S.C.C.A.N. 2313-279).[4] In concluding that § 1396r created a private right of action, the Court of Appeals in *Rolland* found that

> [t]he NHRA speaks largely in terms of the persons intended to be benefited, nursing home residents. . . . The statute contains a laundry list of rights to be afforded residents and commands certain state and nursing home activities in order to ensure that residents receive necessary services. In short, after clearly identifying those it seeks to protect, the statute goes on to endow them with particular rights, utilizing "rights-creating" language.

Rolland, 318 F.3d at 53.

Just as we held in *Sabree*, we hold here that the specific rights conferred by the FNHRA could not be clearer. Indeed, the rights-creating language here may be even stronger than the language at issue in *Sabree* as Congress explicitly included the word "rights" when identifying the expectations and entitlements of nursing home residents. See 42 U.S.C. § 1396r(c)(1)(A). Viewing the terms of the

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[4] We recognize that the Supreme Court cautioned that we should consider specific statutory provisions as opposed to a statute as a whole in determining whether an enforceable right exists. *Blessing*, 520 U.S. at 342-43. Nonetheless, courts often consider the legislative history of the entire statute in determining Congressional intent. *See, e.g., Wilder*, 496 U.S. at 516-17; *Rabin*, 362 F.3d at 196-97 ("[T]he interpretation given to the statute must be consistent with the congressional purpose for enacting it.") (citing *Holloway v. U.S.*, 526 U.S. 1, 9 (1999)).

FNHRA next to Title VI, Title IX, FERPA, and Medicaid's reasonable promptness provisions, through the lens of *Gonzaga Univ.*, we hold that Congress did use rights-creating language sufficient to unambiguously confer individually enforceable rights.

E.

We have one final step in our analysis. The Supreme Court instructs that we are to examine not only the text of the statute at issue, but also its structure to satisfy ourselves that it is sufficiently rights-creating. *See Gonzaga Univ.*, 536 U.S. at 286; *see also Sabree*, 367 F.3d at 191. As we did in *Sabree*, we look beyond the provisions identified by the Appellant and instead change our focus to the structural elements of Title XIX as a whole. The scenery has not changed since our opinion in *Sabree*. We recognize that provisions within the Medicaid Act speak in terms of an "agreement between Congress and a particular state." *See Sabree*, 367 F.3d at 191. Other provisions, 42 U.S.C. § 1396[c] for example, empower the Secretary of Housing [*sic*] and Human Services to suspend payments to a state if it fails to "comply substantially" with the title's requirements. These provisions gave us pause in *Sabree*, and they continue to cause us some reticence today. *See Sabree*, 367 F.3d at 191; *Newark Parents Ass'n.*, 547 F.3d at 211-12. *Sabree* counsels, however, that we must consider the existence of rights-creating language in other relevant statutory provisions of Title XIX. *Sabree*, 367 F.3d at 192. We found that the existence of other provisions (Medicaid's appropriations and enforcement provisions, for example) could

not "neutralize" the rights-creating language that was found in the specific provisions at issue. *Id.* Thus, *Sabree* created a test whereby courts should balance the strength of the specific language of the statutory provisions at issue against the larger structural elements of the statute.[5] The language used throughout the FNHRA is explicitly and unambiguously rights-creating, despite the countervailing elements of the statute. The larger statutory structure, therefore, does not neutralize the rights-creating language contained throughout the FNHRA.

F.

Accordingly, the various provisions of the FNHRA under which Grammer sues do confer individual rights that are presumptively enforceable through § 1983. The burden shifts to the Kane Center to rebut the presumption of an enforceable right under § 1983. *Sabree*, 367 F.3d at 193. The Kane Center has not satisfied its burden here, as it fails to argue that Congress precluded individual enforcement of the rights conferred by the FNHRA in any way. Moreover, our independent examination and assessment of the Medicaid Act disclosed no evidence of congressional intent to preclude enforcement of the rights created by the various provisions of this statute. This is so because no provision contains express terms to that effect and no comprehensive

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[5] By comparison, we determined that the "less-than rights-creating language" found in *Newark Parents Ass'n.* was neutralized by the overall structure of the No Child Left Behind Act, 20 U.S.C. § 6301 et seq. 547 F.3d at 211-12.

remedial scheme is established by the provisions at issue. *See Gonzaga Univ.*, 536 U.S. at 284-85; *Blessing*, 520 U.S. at 341. As we held in *Sabree*, "Title XIX contains no provisions explicitly precluding individual actions." 367 F.3d at 193.

V.

In sum, it is clear enough that Congress intended to create individual rights in drafting and adopting § 1396r, and that Appellant's mother falls squarely within the zone of interest these provisions are meant to protect. Hence, we hold that the statutory provisions which Grammer seeks to enforce under § 1983 satisfy both *Gonzaga Univ.'s* insistence on rights-creating language as evidence of Congressional intent and *Blessing's* remaining factors. We will reverse the order of the District Court and remand the cause for further proceedings.

STAFFORD, District Judge, dissenting.

Because I cannot agree that the district court erred in granting the defendant's motion to dismiss, I must respectfully dissent. The district court determined—I believe correctly—that Appellant may not sue Appellee, a nursing home, for violations of 42 U.S.C. § 1396r under 42 U.S.C. § 1983.

The Medicaid Act (the "Act"), which contains the statutory provisions allegedly violated by Appellee, is Spending Clause legislation. Spending Clause legislation rarely confers upon funding beneficiaries the right to bring private actions "before thousands of federal- and state-court judges" against funding

recipients. *Gonzaga*, 536 U.S. at 290; *Newark Parents Ass'n*, 547 F.3d at 205, 214 (this circuit's latest foray into the rights-creating-language thicket). The Supreme Court has been explicit: "[U]nless Congress 'speak[s] with a clear voice,' and manifests an 'unambiguous' intent to confer individual rights, federal funding provisions provide no basis for private enforcement by § 1983." *Gonzaga*, 536 U.S. at 280 (quoting *Pennhurst State Sch. and Hosp. v. Halderman*, 451 U.S. 1, 17). In section 1396r, Congress did not speak with a "clear voice" or manifest an "unambiguous intent" to provide a basis for private enforcement of funding requirements under section 1983.

The Supreme Court in *Gonzaga* emphasized that "[s]tatutes that focus on the person regulated rather than the individuals protected create no implication of an intent to confer rights on a particular class of persons." *Gonzaga*, 536 U.S. at 287 (internal quotations marks and citations omitted). In *Newark Parents Ass'n*, this court likewise recognized that "where a statute focuses on the entity to be regulated . . . and the benefit to be conferred on an individual is secondary, i.e., it flows to individuals as a result of the regulation of the States and [recipient] agencies, Congress has not created the type of individual entitlement that characterize [sic] the unambiguous intent to create personal rights." *Newark Parents Ass'n*, 547 F.3d at 213.[6]

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[6] In *Gonzaga*, 536 U.S. at 285, the Court explained that "[a] court's role in discerning whether personal rights exist in the § 1983 context should . . . not differ from its role in discerning whether personal rights exist in the implied right of action

(continued)

Under the Medicaid Act, the federal government directs funding to states to assist them in providing medical assistance to certain eligible individuals. To receive federal funds under the Medicaid Act, states are required to administer low-income medical assistance programs pursuant to "State plans" approved by the Secretary of Health and Human Services. The Act sets forth detailed requirements for state plans. Among many other things, the Act provides that "[a] State plan for medical assistance must . . . provide . . . that any nursing facility receiving payments under such plan must satisfy all the requirements of subsections (b) through (d) of section 1396r." 42 U.S.C. 1396a(a)(28)(A). Section 1396r lists the requirements that nursing facilities—as recipients of federal funding—must meet relating to the provision of services to its Medicaid patients. Importantly, in each of the provisions in subsections

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context." In the implied right of action context, federal courts have consistently held that no implied private right of action exists under the Medicaid Act, OBRA, or FNHRA. *See, e.g.*, *Prince v. Dicker*, No. 01-7805, 29 Fed. Appx. 52, 2002 WL 226492 at *2 (2d Cir. 2002) (holding, with no discussion, that 42 U.S.C. § 1396r did not confer a private right of action that could be enforced against a private nursing home); *Brogdon v. Nat'l Healthcare Corp.*, 103 F. Supp. 2d 1322, 1330-32 (N.D. Ga. 2000) (finding that Congress did not intend to authorize nursing home residents to file suit against nursing facilities to enforce the section 1396r standards required for participation in the Medicaid program); *Sparr v. Berks County*, 2002 WL 1608243 *2-3 (E.D. Pa. July 18, 2002) (dismissing action brought by executor of patient's estate against the nursing home for violations of the FNHRA, finding that although the statute was enacted to benefit the plaintiff, there was nothing in the legislative purpose or history to suggest that Congress intended to create a private right of action).

(b) through (d), namely, subsections (b)(1)-(8), (c)(1)-(8) and (d)(1)-(4), Congress began by stating: "The nursing facility must . . . " In each case, the focus is on what the nursing facility must do in return for federal funds; the focus is not on the individuals to whom the benefit of each provision flows.[7]

In *Gonzaga*, the Supreme Court noted that its "more recent decisions . . . have rejected attempts to infer enforceable rights from Spending Clause statutes." *Id.* at 281. Whatever *Sabree* may say as to section 1396a, I do not agree that Congress intended to confer upon nursing home residents the right to invoke section 1983 to sue individual nursing homes for alleged violations of the non-monetary service requirements set forth in section 1396r. The district court properly dismissed the case, and we should affirm.

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[7] In *Newark Parents Ass'n*, this court compared the language used in the No Child Left Behind Act ("NCLBA") (the statute at issue in *Newark*) with the language used in the two exemplars of rights-creating language cited by the *Gonzaga* Court (Title VI of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972), stating as follows:

> [T]he terms used in the relevant provisions of the NCLBA . . . are materially distinguishable from the language found in Titles VI and IX. The command used in those statutes—"No person . . . shall . . . be subjected to discrimination"—makes its one and only subject a "person." In the NCLBA, there are two subjects: the primary subject is always the State and the "local educational agency," while "the parents of each student" are the secondary subject—they benefit from the provision but only as a result of regulation imposed upon the State and its actors.

Newark Parents Ass'n, 547 F.3d at 210.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF
PENNSYLVANIA

SARAH GRAMMAR, as Administratrix of the Estate of Melvinteen Daniels, Deceased,	)	
Plaintiff,	)	
	)	Civil Action No. 06-781
v.	)	
	)	Judge Lancaster
JOHN J. KANE REGIONAL CENTERS – GLEN HAZEL,	)	Magistrate Judge Hay
Defendant.	)	

ORDER

AND NOW, this 6th day of April, 2007, after the plaintiff, Sarah Grammar, filed an action in the above-captioned case, and after a motion to dismiss was submitted by defendant, and after a Report and Recommendation was filed by the United States Magistrate Judge granting the parties ten days after being served with a copy to file written objections thereto, upon consideration of the objections filed by plaintiff and the response to those objections filed by defendant, and upon independent review of the

record, and upon consideration of the Magistrate Judge's Report and Recommendation.

IT IS HEREBY ORDERED that the Report an[d] Recommendation is amended as follows: the last sentence of the first paragraph appearing on page 6 of the Report and Recommendation is stricken as being an overly broad interpretation of the Supreme Court's holding in *Gonzaga University v. Doe*, 536 U.S. 273 (2002), and superfluous to the analysis.

IT IS FURTHER ORDERED that the Report and Recommendation is otherwise adopted as the opinion of the Court and that defendant's motion to dismiss (Dkt. No. 9) is granted.

IT IS FINALLY ORDERED that, pursuant to Rule 4(a)(1) of the Federal Rules of Appellate Procedure, if the plaintiff desires to appeal from this Order she must do so within thirty (30) days by filing a notice of appeal as provided in Rule 3, Fed. R. App. P.

s/Gary L. Lancaster
GARY L. LANCASTER
United States District Judge

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF
PENNSYLVANIA

SARAH GRAMMAR, as Administratrix of the Estate of Melvinteen Daniels, Deceased,	)	
Plaintiff,	)	
	)	Civil Action No. 06-781
v.	)	
	)	Judge Lancaster
JOHN J. KANE REGIONAL CENTERS – GLEN HAZEL,	)	Magistrate Judge Hay
Defendant.	)	

REPORT AND RECOMMENDATION

I. RECOMMENDATION

It is respectfully recommended that the motion to dismiss submitted on behalf of defendant (Docket No. 9) be granted.

II. REPORT

Plaintiff, Sarah Grammar, commenced this action against defendant John J. Kane Regional Centers - Glen Hazel ("the Kane Center"), alleging that the Kane Center failed to provide her mother, Melvinteen Daniels, with proper care. Plaintiff al-

leges that as a result, Ms. Daniels developed decubitus ulcers, suffered from malnutrition and was eventually diagnosed with sepsis which ultimately led to her death on January 22, 2005.

Plaintiff filed the instant complaint on June 13, 2006, bringing claims under § 1983 for wrongful death (Count I) and survival (Count II). Plaintiff alleges that defendant had a duty under the Omnibus Budget Reconciliation Act of 1987 ("OBRA"), the Federal Nursing Home Reform Act ("FNHRA"), 42 U.S.C. § 1396r, *et seq.*, and the implementing regulations found at 42 C.F.R. § 483, *et seq.*, to ensure quality care for its residents and that by failing to provide such care as delineated under the statute plaintiff has been deprived of her civil rights.

These statutes and the government programs they govern have been previously summarized by this Court as follows:

> Title XVIII of the Social Security Act establishing the Medicare Program, 42 U.S.C. § 1395 et seq., and Title XIX of the Social Security Act establishing the Medicaid Program, 42 U.S.C. § 1396 et seq., each provides that the federal Department of Health and Human Services is responsible for overall administration of the programs. Medicaid, a joint federal/state program, is administered by the individual states which, in order to participate in the program, must agree to comply with the requirements and standards of the Medicaid Act. 42 U.S.C. § 1396a. Private individuals and organizations such as the Plaintiff contract with HHS and the respective states to provide medical services, including residential skilled nursing care, to the elderly, disabled

and/or low-income individuals covered by Medicare and Medicaid.

HHS has delegated implementation of Medicare regulations and compliance with the health and safety standards established for the skilled nursing facilities to the Health Care Financing Administration. HCFA in turn contracts with agencies in each state to conduct on-site surveys to determine if the providers meet those standards. In Pennsylvania, the Department of Public Welfare is responsible for those surveys. To be certified as a "nursing facility," the organization must comply with the requirements of 42 U.S.C. § 1395i-3(b)-(d) for provision of services under Medicare and 42 U.S.C. § 1396r(b)-(d) for Medicaid services, as well as with the extensive regulations promulgated by the Secretary of HHS. Once a Pennsylvania provider has been initially certified, the DPW conducts periodic re-inspections to assure that those standards are maintained. 42 U.S.C. § 1395i-3(g); 42 U.S.C. § 1396(g). The Medicare and Medicaid standards are nearly identical.

In 1987, as part of the Omnibus Budget Reconciliation Act ("OBRA 87"), Congress amended the Social Security Act to require higher standards of safety, physical and mental care, and rights of residents at nursing homes. Federal Nursing Home Reform Act, Pub. L. No. 110-203, codified at 42 U.S.C. §§ 1395i-3 and 1396r. These changes led in turn to more stringent standards for nursing home accreditation and participation. Until the OBRA 87 amendments, only two sanctions were available for nursing homes that failed to meet participation requirements. If the severity

> of the non-compliance (the so-called "deficiency") posed "immediate jeopardy" to the well-being of the residents, the Secretary of Health and Human Services or the State could decertify the facility and terminate its eligibility to receive Medicaid reimbursements. If, on the other hand, the deficiency did not pose an immediate and serious threat to the patients' health and safety, HHS or the State could deny payment for new admissions for up to eleven months. *Brogdon v. National Healthcare Corp.*, 103 F. Supp. 2d 1322, 1327 (N.D. Ga. 2000). However, the OBRA 87 amendments not only imposed unscheduled "standard surveys" and "extended surveys" that determined if the facility met specific standards, they also provided a number of new sanctions to encourage compliance. These so-called "remedies" included denial of payments, civil monetary penalties for each day of non-compliance, appointment of temporary management, and under Medicaid, closure of the facility and transfer of residents to other facilities. *Brogdon, id.*, citing 42 U.S.C. §§ 1395i-3(h)(2)(B) and 1396r(h)(2)(A), (h)(3).

Trade Around the World of PA v. Shalala, 145 F. Supp. 2d 653, 655-656 (W.D. Pa. 2001).

It is against this backdrop that we address defendant's motion to dismiss in which it argues that no private right of action exists directly under the OBRA or the FNHRA and that Congress did not intend the statute to create a federal right enforceable through § 1983. Rather, defendant argues, the statutory provisions cited by plaintiff merely set forth the requirements that a nursing facility must

comply with in order to qualify for federal funding under the Medicaid Act.

In reviewing a motion to dismiss under Rule 12(b)(6), all well pleaded allegations of the complaint must be accepted as true and viewed in a light most favorable to the nonmovant. *Brader v. Allegheny General Hospital*, 64 F.3d 869, 873 (3d Cir. 1995); *Scrob v. Patterson*, 948 F.2d 1402, 1405 (3d Cir. 1991). The Court is not, however, required to accept as true unsupported conclusions and unwarranted inferences. *Schuylkill Energy Resources v. PP&L*, 113 F.3d 405, 417 (3d Cir. 1997). Thus, "if it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief," the motion to dismiss is properly granted. *Haines v. Kerner*, 404 U.S. 519, 520-21 (1972), quoting *Conley v. Gibson*, 355 U.S. 41, 45-46 (1957). The issue is not whether the plaintiff will prevail in the end but only whether he should be entitled to offer evidence in support of his claim. *Scheuer v. Rhodes*, 416 U.S. 232, 236 (1974).

Under § 1983, liability will be imposed on anyone who, acting under the color of state law, deprives a person "of any rights, privileges, or immunities secured by the Constitution and laws." 42 U.S.C. § 1983. The Supreme Court of the United States has held that § 1983 protection extends to violations of federal statutes as well as the Constitution. *Maine v. Thiboutot*, 484 U.S. 1, 4 (1980). In order to have a cause of action under § 1983, however, "a plaintiff must assert the violation of a federal *right*, not merely a violation of federal *law*." *Blessing v. Freestone*, 520 U.S. 329, 340 (1997) ("*Blessing*").

To determine whether a particular statutory provision gives rise to a federal right Courts typically have applied what has become known as the "Blessing test":

> First, Congress must have intended that the provision in question benefit the plaintiff. *Wright* [*v. Roanoke Redevelopment and Housing Authority*], 479 U.S. [418], 430 [(1987)]. . . . Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so "vague and amorphous" that its enforcement would strain judicial competence. *Id.*, at 431-432. . . . . Third, the statute must unambiguously impose a binding obligation on the States. In other words, the provision giving rise to the asserted right must be couched in mandatory, rather than precatory, terms. *Wilder* [*v. Virginia Hospital Assn.*, 496 U.S. 498,] 510-511 [(1990)]. . . .

Blessing, 520 U.S. at 340-41. Concerned that some courts were interpreting *Blessing* as allowing plaintiffs to enforce statutes under § 1983 merely because they fall within the "zone of interests that the statute is intended to protect," or "something less than what is required for a statute to create enforceable rights directly from the statute itself under an implied right of action," the Supreme Court subsequently made clear that a plaintiff must show that Congress intended to create an "unambiguously conferred right" by pointing to clear and unambiguous "rights-creating language." *Gonzaga University v. Doe*, 536 U.S. 273, 283, 290 (2002) ("*Gonzaga*").

In so holding, the Supreme Court found that the determination of whether a statute confers rights enforceable under § 1983 should be guided by im-

plied right of action cases expressly rejecting the notion that the two lines of cases are separate and distinct. *Id.* at 283. Rather, the Court found that the questions of whether a statutory violation may be enforced through § 1983 and whether a private right of action can be implied from a particular statute overlap in that the initial inquiry in a § 1983 action – whether a statute confers a right – "is no different from the initial inquiry in an implied right of action case, the express purpose of which is to determine whether or not a statute 'confer[s] rights on a particular class of persons.'" *Id.* at 285, quoting *California v. Sierra Club*, 451 U.S. 287, 294 (1981). The Court therefore concluded that "[a] Court's role in discerning whether personal rights exist in the § 1983 context should . . . not differ from its role in discerning whether personal rights exist in the implied right of action context." *Id.* at 285.

In the instant case, defendant has argued, and plaintiff does not dispute, that neither the OBRA nor the FNHRA provides for a private right of action. Indeed, defendant has cited to a number of cases that have so held in which, like the instant case, an individual seeking monetary damages has brought suit directly against a provider for violations under the FNHRA. *See Solter v. Health Partners of Philadelphia, Inc.*, 215 F. Supp. 2d 533, 540 (E.D. Pa. 2002) ("*Solter*") (Finding that plaintiff had no private right of action against her health insurer and its agent under the Medicaid Act for denying treatment.); *Brogdon ex rel. Cline v. National Healthcare Corp.*, 103 F. Supp. 2d 1322, 1330-32 (N.D. Ga. 2000) ("*Brogdon*") (Finding that Congress did not intend to authorize nursing home residents to file suit against

nursing homes to enforce the standards required for participation in the Medicare and Medicaid programs.); *Nichols v. St. Luke Center of Hyde Park*, 800 F. Supp. 1564, 1567-68 (S.D. Ohio 1992) (Finding that no private right of action exists under Medicaid Act.); *Chalfin v. Beverly Enterprises, Inc.*, 741 F. Supp. 1162, 1166-67 (E.D. Pa. 1989) (Dismissing claims brought by nursing home patient against nursing home finding that Congress did not intend to create a private right of action under the Social Security Act.); *Ratmansky ex rel. Ratmansky v. Plymouth House Nursing Home, Inc.*, 2005 WL 770628 *3 (E.D. Pa. April 5, 2005) (Finding that the Medicare Act and regulations do not create a private right of action against nursing home.); *Sparr v. Berks County*, 2002 WL 1608243 *2-3 (E.D. Pa. July 18, 2002) (Dismissing action brought by executor of patient's estate against the nursing home for violations of the FNHRA finding that although the statute was enacted to benefit the plaintiff there was nothing in the legislative purpose or history to suggest that Congress intended to create a private right of action.); *Andrusichen v. Extendicare Health Services, Inc.*, 2002 WL 1743576 *2-3 (E.D. Pa. July 23, 2002) (same). *See also Tinder v. Lewis County Nursing Home District*, 207 F. Supp. 2d 951, 957 (E.D. Mo. 2001) (Finding Congress did not intend to create a private right of action under the OBRA or FNHRA). Because *Gonzaga* instructs that where there is no implied right of action under a statute, there is no right enforceable under § 1983, it follows from these cases that plaintiff has no enforceable right under § 1983 and, thus, has failed to state a claim.

Notably, plaintiff has not discussed the cases relied upon by defendant or cited to any cases that have held that a private right of action exists under the OBRA or FNHRA. Indeed, plaintiff has not addressed defendant's argument in this regard at all but rather cites to several cases in which § 1983 actions brought against the state for violations of the Medicaid Act have been permitted to go forward. *See Sabree ex rel. Sabree v. Richman*, 367 F.3d 180 (3d Cir. 2004) ("*Sabree*"); *Rolland v. Romney*, 318 F.3d 42 (1st 2003) ("*Rolland*"); *Tinder v. Lewis County Nursing Home District*, 207 F. Supp. 2d 951 (E.D. Mo. 2001) ("*Tinder*"). These cases, however, are easily distinguishable from the case at bar.

In *Tinder*, like in the instant case, the plaintiffs brought a § 1983 action against the county nursing home where their father had been a resident. Unlike the instant case, however, the plaintiffs also brought claims directly under the OBRA and FNHRA. Although the Court dismissed the claims brought directly under the OBRA and FNHRA, finding that Congress did not intend to establish a private right of action under those statutes, it found that the alleged OBRA violations could form the basis for the plaintiffs' § 1983 claims. *Id.* at 955, 957. *Tinder*, however, was decided before the Supreme Court made clear in *Gonzaga* that the inquiries involved in determining whether a statute confers a right enforceable under § 1983 and whether an implied right of action exists is no different. Moreover, in deciding that the OBRA may provide the basis for a § 1983 claim, the court did not engage in any analysis whatsoever or even mention the standards set forth in either *Blessing* or *Gonzaga* for assessing whether

Congress intended to confer an enforceable right. Under these circumstances, *Tinder* provides little support for plaintiff's position.

Further, in both *Sabree* and *Rolland*, and in seemingly every other § 1983 case in which it was found that the Medicaid Act created an enforceable right, the case was brought against the state itself or the state agency responsible for implementing the provisions of the Medicaid Act rather than directly against the care provider. Moreover, the relief sought by the plaintiffs was in the form of injunctive relief rather than the monetary damages sought by plaintiff here. *See Watson v. Weeks*, 436 F.3d 1152 (9th Cir.), *cert. denied*, ___ U.S. ___, 127 S. Ct. 598 (2006) (Medicaid eligible individuals brought § 1983 suit against Director of Oregon Department of Human Services and other state health officials seeking injunctive and declaratory relief.); *Rabin v. Wilson-Coker*, 362 F.3d 190 (2nd Cir. 2004) (Medicaid recipients brought § 1983 action against Commissioner of the Connecticut Department of Social Services claiming they were entitled to transitional medical assistance after the state lowered its income eligibility limits.); *Clark v. Richman*, 339 F. Supp. 2d 631 (M.D. Pa. 2004) (Medicaid recipients brought suit under § 1983 against Secretary of the Pennsylvania Department of Public Welfare seeking enforcement of certain provisions of the Medicaid Act.); *Ottis v. Shalala*, 862 F. Supp. 182 (W.D. Mich. 1994) (Residents of Michigan nursing homes brought § 1983 action against the Secretary of Health and Human Services and other state health officials asking Court to order defendants to establish and implement enforcement procedures and remedies required under the OBRA.);

Conner v. Branstad, 839 F. Supp. 1346 (S.D. Iowa 1993) (Group of institutionalized disabled individuals brought § 1983 action against the Governor of the state of Iowa and the Director of the Department of Human Services challenging the state's system of providing services.). Although plaintiff argues that these are distinctions without a difference, we disagree.

Indeed, the distinction appears to lie in the fact that the Medicaid Act merely sets forth the requirements that the Secretary of Health and Human Services must implement and the services that the state must require nursing facilities to provide if the state wants to qualify for federal funding. Thus, the statute imposes a duty only on states which choose to participate in the program and not on the nursing homes that provide medical services. As stated by the District Court for the Eastern District of Pennsylvania,

> [I]n order to qualify for federal assistance, a participating state must submit to the Secretary and have approved "a state plan for medical assistance." *Wilder* [*v. Virginia Hospital Assoc.*], 496 U.S. [498,] 501 . . . [which] must "include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which ... are consistent with the objectives [of the Medicaid Act]." 42 U.S.C. § 1396a(a)(17).
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> * * *
>
> The Medicaid program embodies a partnership between the federal government and the states, which involves a combination of federal funding and state administration. . . . "It is clear from the

> legislative history that, rather than focusing on the individual patient, the legislation is primarily directed at the role of participating *states* in providing medical care with the assistance of federal funds." *Chalfin*, 741 F. Supp. at 1169 (emphasis in original). "The Medicaid program is not intended to meet all the medical needs of recipients. Rather, its goal is to provide medical assistance 'as far as practicable under the conditions of [each] state.'" *Id.* (quoting *Bumpus v. Clark*, 681 F.2d 679, 684 (9th Cir. 1982) (quoting 42 U.S.C. § 1396)).

Solter, 215 F. Supp. 2d at 535, 540. *See Brogdon*, 103 F. Supp. 2d at 1327 (Finding that if a state chooses to participate in the Medicaid program in order to receive funding from the federal government, it is the state that must comply with the requirements of the Act and its implementing regulations by submitting and enforcing an appropriate state plan.); *Andrusichen v. Extendicare Health Services, Inc.*, 2002 WL 1743576 at * 2, quoting *Chalfin v. Beverly Enterprises, Inc.*, 741 F. Supp. 1162, 1167 (E.D. Pa. 1989) ("The statute is about disbursement of funds and the conditions a recipient of those funds must comply with. . . . [T]he legislation is primarily directed at the role of participating *states* in providing medical care with the assistance of federal funds. The bill attempts to outline certain requirements which the *state* must comply with in order to become and remain eligible for federal funding."). *See also Trade Around the World of PA v. Shalala*, 145 F. Supp. 2d at 655-56. Because the Medicaid Act speaks to the states and their obligations thereunder, it follows the states should be held account-

able by those who are ultimately harmed when the state does not fulfill its obligations. It does not follow that an individual may bring a personal injury claim against a nursing home for providing insufficient care since the statute does not impose a duty on nursing care providers.

In this manner, our conclusion that plaintiff here has no private right of action and no federal right to enforce the provisions of the Medicaid Act against the Kane Center is not inconsistent with the Third Circuit's decision in *Sabree*. Although in *Sabree*, the Court found that the Medicaid Act unambiguously conferred the rights which the plaintiffs sought to enforce, the right at issue in that case was the right to have the state, and more specifically Pennsylvania's Secretary of Health and Human Services, provide certain services that the plaintiffs qualified for under Pennsylvania's medical assistance plan. *Sabree*, 367 F.3d at 181, 182, 189, 194. Indeed, the Court repeatedly framed the issue in terms of the plaintiffs' right to sue Pennsylvania to enforce the provisions of the Medicaid Act that required Pennsylvania to provide medical assistance covering the services sought by the plaintiffs. *Id.* at 182, 189. Opining that the provisions at issue "indisputably . . . create law binding on those states choosing to accept Medicaid funding," the Court was able to conclude that the provisions satisfied the *Blessing* test not only because the plaintiffs were the intended beneficiaries of the provisions and the rights sought to be enforced – i.e., requiring states which accept Medicaid funding to provide ICF/MR services – are specific and enumerated, but because the obligation imposed on the states to provide those services is

unambiguous and binding. *Id.* at 189 (emphasis added). *See Blessing*, 520 U.S. at 340-41. Having found that the Medicaid Act is binding on the states it follows that it may be enforced against the state.

Here, however, unlike in *Sabree*, plaintiff is not proceeding against the state agency responsible for implementing and overseeing the relevant provisions of the Medicaid Act. Thus, whether the statute imposes a binding obligation on the *states* – the third *Blessing* factor – appears irrelevant since the question in this case is whether plaintiff has an enforceable right against the nursing home. The relevant question therefore would appear to be whether the statute imposes a binding obligation on the nursing homes that actually provide the services which does not appear to be the case. *See Solter*, 215 F. Supp. 2d at 535, 440; *Trade Around the World of PA v. Shalala*, 145 F. Supp. 2d at 655- 656; *Brogdon*, 103 F. Supp. 2d at 1327; *Andrusichen*, 2002 WL 1743576 at *2. Moreover, the fact that plaintiff seeks monetary damages against the nursing home for failing to provide proper care rather than seeking to require the state to implement the provisions of the Medicaid Act suggests that this case is more akin to a private right of action case which plaintiff does not dispute is unavailable under the OBRA and the FNHRA.[1]

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[1] Although the Court is cognizant of the fact that the Kane Center is a county owned and operated facility which appears to render it a "state actor" for purposes of § 1983, it does not alter the fact that it is not the state entity to which the Medicaid Act speaks. Moreover, as argued by defendant, Congress could not have intended to create a right in individuals to bring suit against county run nursing homes under § 1983 for alleged

(continued)

While, to be sure, nursing home residents are within the "zone of interest" that the Medicaid Act was designed to protect, neither the structure nor the text of the statute suggest that Congress intended it to be a device through which individuals could bring suit directly against a nursing home under either an implied right of action or § 1983. *See Gonzaga*, 536 U.S. at 286 ("[W]here the text and structure of the statute provide no indication that Congress intends to create new individual rights, there is no basis for a private suit, whether under § 1983 or under an implied right of action.). *See also Solter*, 215 F. Supp. 2d at 540 (Finding no implied private right of action, in part, because "[i]mplying a federal cause of action which would place enforcement of the Medicaid Act in the federal courts . . . would significantly distort the congressional scheme of placing administration of the program under the Medicaid Act in the hands of the states.") Indeed, other than *Tinder*, plaintiff has not cited to one case, nor has the Court uncovered one, where an individual seeking monetary damages was permitted to proceed against a nursing home under § 1983 or an implied private right of action for alleged violations of the OBRA or FNHRA. Under these circumstances, it appears that plaintiff has no enforceable right under the OBRA and FNHRA against the Kane Center and, consequently, has failed to state a claim under § 1983.[2]

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violations of the Medicaid Act when they could not proceed directly against private nursing homes for the same violations.

[2] Although the Court recognizes that it concluded otherwise in *Quinlan v. John J. Kane Regional Centers - Glen Hazel*, Civ. Action No. 04-0485 (W.D. Pa. 2005), a decision which is not (continued)

Having found that plaintiff is unable to demonstrate that a federal right has been unambiguously conferred by Congress in the first instance, we need not address defendant's alternative argument that Congress nevertheless did not intend the right to be enforceable under § 1983. *See Blessing*, 520 U.S. at 341; *Sabree*, 367 F.3d at 193.

For these reasons, it is recommended that the motion to dismiss submitted on behalf of defendant (Docket No. 9) be granted.

Within ten (10) days of being served with a copy, any party may serve and file written objections to this Report and Recommendation. Any party opposing the objections shall have seven (7) days from the date of service of objections to respond thereto. Failure to file timely objections may constitute a waiver of any appellate rights.

s/Amy Reynolds Hay
AMY REYNOLDS HAY
United States Magistrate Judge

Dated: 6 March, 2007.

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binding here, defendant at that time made little to no argument in support of its motion to dismiss but merely concluded that plaintiff had failed to point to any "clear and unambiguous rights-creating language" in the amended complaint. It did not make the arguments as it has here regarding the absence of an implied private right of action under the OBRA and FNHRA, the structure and purpose of the statutes, or the apparent absence of any § 1983 cases in which the plaintiff was proceeding directly against the nursing home for monetary damages. Because the Court finds these arguments compelling we have reached a contrary result in this case.

APPENDIX D

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 07-2358

SARAH GRAMMER, as Administratrix of the Estate of Melvinteen Daniels, Deceased,
Appellant

v.

JOHN J. KANE REGIONAL CENTERS – GLEN HAZEL
Appellee

On Appeal from the United States District Court
for the Western District of Pennsylvania
(D.C. No. 06-cv-00781)
District Judge: The Honorable Gary L. Lancaster

ARGUED MAY 20, 2008

Present: SCIRICA, *Chief Judge*, SLOVITER, McKEE, RENDELL, BARRY, AMBRO, FUENTES, SMITH, FISHER, CHAGARES, JORDAN, HARDIMAN, and

NYGAARD, *Circuit Judges*, and STAFFORD, *District Judge*[*]

SUR PETITION FOR REHEARING

The petition for rehearing filed by Appellee John J. Kane Regional Centers – Glen Hazel, having been submitted to all judges who participated in the decision of this court, and to all the other available circuit judges in active service, and a majority of the judges who concurred in the decision not having asked for rehearing, and a majority of the circuit judges of the circuit in regular active service not having voted for rehearing by the court in banc, the petition for rehearing is hereby DENIED. Judge Stafford voted to grant panel rehearing.

BY THE COURT:

/s/ Richard L. Nygaard
United States Circuit Judge

Dated: August 14, 2009

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[*] Honorable William H. Stafford, Jr., Senior District Judge for the United States District Court for the Northern District of Florida, sitting by designation. Judge Stafford's vote is limited to panel rehearing only.

APPENDIX E

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

1. Article I, Section 8, Clause 1 of the United States Constitution (Spending Clause) provides, in relevant part:

The Congress shall have Power to lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States . . . .

2. Section 1396 of Title 42, United States Code, provides:

§ 1396. Appropriations

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

3. Section 1396a of Title 42, United States Code, provides, in relevant part:

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

* * * * *

(28) provide—

(A) that any nursing facility receiving payments under such plan must satisfy all the requirements of subsections (b) through (d) of section 1396r of this title as they apply to such facilities;

* * * * *

4. Section 1396c of Title 42, United States Code, provides:

§ 1396c. Operation of State plans

If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure

to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

5. Section 1396r of Title 42, United States Code, provides, in relevant part:

§ 1396r. Requirements for nursing facilities

(a) "Nursing facility" defined

In this subchapter, the term "nursing facility" means an institution (or a distinct part of an institution) which—

(1) is primarily engaged in providing to residents—

(A) skilled nursing care and related services for residents who require medical or nursing care,

(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

(C) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities,

and is not primarily for the care and treatment of mental diseases;

(2) has in effect a transfer agreement (meeting the requirements of section 1395x(*l*) of this title) with one or more hospitals having agreements in effect under section 1395cc of this title; and

(3) meets the requirements for a nursing facility described in subsections (b), (c), and (d) of this section.

* * * * *

(b) Requirements relating to provision of services

(1) Quality of life

(A) In general

A nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

(B) Quality assessment and assurance

A nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph.

(2) Scope of services and activities under plan of care

A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care which—

(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

(3) Residents' assessment

(A) Requirement

A nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—

(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

(ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A) of this section;

(iii) uses an instrument which is specified by the State under subsection (e)(5) of this section; and

(iv) includes the identification of medical problems.

(B) Certification

(i) In general

Each such assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment.

(ii) Penalty for falsification

(I) An individual who willfully and knowingly certifies under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 with respect to each assessment.

(II) An individual who willfully and knowingly causes another individual to certify under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 with respect to each assessment.

(III) The provisions of section 1320a-7a of this title (other than subsections

(a) and (b)) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(iii) Use of independent assessors

If a State determines, under a survey under subsection (g) of this section or otherwise, that there has been a knowing and willful certification of false assessments under this paragraph, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.

(C) Frequency

(i) In general

Such an assessment must be conducted—

(I) promptly upon (but no later than 14 days after the date of) admission for each individual admitted on or after October 1, 1990, and by not later than October 1, 1991, for each resident of the facility on that date;

(II) promptly after a significant change in the resident's physical or mental condition; and

(III) in no case less often than once every 12 months.

(ii) Resident review

The nursing facility must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment.

(D) Use

The results of such an assessment shall be used in developing, reviewing, and revising the resident's plan of care under paragraph (2).

(E) Coordination

Such assessments shall be coordinated with any State-required preadmission screening program to the maximum extent practicable in order to avoid duplicative testing and effort. In addition, a nursing facility shall notify the State mental health authority or State mental retardation or developmental disability authority, as applicable, promptly after a significant change in the physical or mental condition of a resident who is mentally ill or mentally retarded.

(F) Requirements relating to preadmission screening for mentally ill and mentally retarded individuals

Except as provided in clauses (ii) and (iii) of subsection (e)(7)(A) of this section, a nursing facility must not admit, on or after January 1, 1989, any new resident who—

(i) is mentally ill (as defined in subsection (e)(7)(G)(i) of this section) unless the State mental health authority has determined (based on an independent physical

and mental evaluation performed by a person or entity other than the State mental health authority) prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires specialized services for mental illness, or

(ii) is mentally retarded (as defined in subsection (e)(7)(G)(ii) of this section) unless the State mental retardation or developmental disability authority has determined prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires specialized services for mental retardation.

A State mental health authority and a State mental retardation or developmental disability authority may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility).

(4) Provision of services and activities

(A) In general

To the extent needed to fulfill all plans of care described in paragraph (2), a nursing facility must provide (or arrange for the provision of)—

(i) nursing and related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(ii) medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident;

(iv) dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident;

(v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident;

(vi) routine dental services (to the extent covered under the State plan) and emergency dental services to meet the needs of each resident; and

(vii) treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State.

The services provided or arranged by the facility must meet professional standards of quality.

(B) Qualified persons providing services

Services described in clauses (i), (ii), (iii), (iv), and (vi) of subparagraph (A) must be provided by qualified persons in accordance with each resident's written plan of care.

(C) Required nursing care; facility waivers

(i) General requirements

With respect to nursing facility services provided on or after October 1, 1990, a nursing facility—

(I) except as provided in clause (ii), must provide 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents, and

(II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week.

(ii) Waiver by State

To the extent that a facility is unable to meet the requirements of clause (i), a State may waive such requirements with respect to the facility if—

(I) the facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing fa-

cilities), to recruit appropriate personnel,

(II) the State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility,

(III) the State finds that, for any such periods in which licensed nursing services are not available, a registered professional nurse or a physician is obligated to respond immediately to telephone calls from the facility,

(IV) the State agency granting a waiver of such requirements provides notice of the waiver to the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and the mentally retarded, and

(V) the nursing facility that is granted such a waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

A waiver under this clause shall be subject to annual review and to the review of the Secretary and subject to clause (iii) shall be accepted by the Secretary for purposes of this subchapter to the same extent as is the State's certification of the facility. In grant-

ing or renewing a waiver, a State may require the facility to use other qualified, licensed personnel.

(iii) Assumption of waiver authority by Secretary

If the Secretary determines that a State has shown a clear pattern and practice of allowing waivers in the absence of diligent efforts by facilities to meet the staffing requirements, the Secretary shall assume and exercise the authority of the State to grant waivers.

(5) Required training of nurse aides

(A) In general

(i) Except as provided in clause (ii), a nursing facility must not use on a full-time basis any individual as a nurse aide in the facility on or after October 1, 1990, for more than 4 months unless the individual—

(I) has completed a training and competency evaluation program, or a competency evaluation program, approved by the State under subsection (e)(1)(A) of this section, and

(II) is competent to provide nursing or nursing-related services.

(ii) A nursing facility must not use on a temporary, per diem, leased, or on any other basis other than as a permanent employee any individual as a nurse aide in the facility on or after January 1, 1991, unless the individual meets the requirements described in clause (i).

(B) Offering competency evaluation programs for current employees

A nursing facility must provide, for individuals used as a nurse aide by the facility as of January 1, 1990, for a competency evaluation program approved by the State under subsection (e)(1) of this section and such preparation as may be necessary for the individual to complete such a program by October 1, 1990.

(C) Competency

The nursing facility must not permit an individual, other than in a training and competency evaluation program approved by the State, to serve as a nurse aide or provide services of a type for which the individual has not demonstrated competency and must not use such an individual as a nurse aide unless the facility has inquired of any State registry established under subsection (e)(2)(A) of this section that the facility believes will include information concerning the individual.

(D) Re-training required

For purposes of subparagraph (A), if, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual performed nursing or nursing-related services for monetary compensation, such individual shall complete a new training and competency evaluation program, or a new competency evaluation program.

(E) Regular in-service education

The nursing facility must provide such regular performance review and regular in-service education as assures that individuals used as nurse aides are competent to perform services as nurse aides, including training for individuals providing nursing and nursing-related services to residents with cognitive impairments.

(F) "Nurse aide" defined

In this paragraph, the term "nurse aide" means any individual providing nursing or nursing-related services to residents in a nursing facility, but does not include an individual—

(i) who is a licensed health professional (as defined in subparagraph (G)) or a registered dietician, or

(ii) who volunteers to provide such services without monetary compensation.

(G) Licensed health professional defined

In this paragraph, the term "licensed health professional" means a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapist, physical or occupational therapy assistant, registered professional nurse, licensed practical nurse, or licensed or certified social worker.

(6) Physician supervision and clinical records

A nursing facility must—

(A) require that the health care of every resident be provided under the supervision of a physician (or, at the option of a State, under the supervision of a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician);

(B) provide for having a physician available to furnish necessary medical care in case of emergency; and

(C) maintain clinical records on all residents, which records include the plans of care (described in paragraph (2)) and the residents' assessments (described in paragraph (3)), as well as the results of any pre-admission screening conducted under subsection (e)(7) of this section.

(7) Required social services

In the case of a nursing facility with more than 120 beds, the facility must have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) employed full-time to provide or assure the provision of social services.

(8) Information on nurse staffing

(A) In general

A nursing facility shall post daily for each shift the current number of licensed and unlicensed nursing staff directly responsible for resident care in the facility. The information shall be displayed in a uniform manner (as specified by the Secretary) and in a clearly visible place.

(B) Publication of data

A nursing facility shall, upon request, make available to the public the nursing staff data described in subparagraph (A).

(c) Requirements relating to residents' rights

(1) General rights

(A) Specified rights

A nursing facility must protect and promote the rights of each resident, including each of the following rights:

(i) Free choice

The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

(ii) Free from restraints

The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

(I) to ensure the physical safety of the resident or other residents, and

(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

(iii) Privacy

The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.

(iv) Confidentiality

The right to confidentiality of personal and clinical records and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

(v) Accommodation of needs

The right—

(I) to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered, and

(II) to receive notice before the room or roommate of the resident in the facility is changed.

(vi) Grievances

The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

(vii) Participation in resident and family groups

The right of the resident to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

(viii) Participation in other activities

The right of the resident to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

(ix) Examination of survey results

The right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Secretary or a State with respect to the facility and any plan of correction in effect with respect to the facility.

(x) Refusal of certain transfers

The right to refuse a transfer to another room within the facility, if a purpose of the transfer is to relocate the resident from a portion of the facility that is not a skilled

nursing facility (for purposes of subchapter XVIII of this chapter) to a portion of the facility that is such a skilled nursing facility.

(xi) Other rights

Any other right established by the Secretary.

Clause (iii) shall not be construed as requiring the provision of a private room. A resident's exercise of a right to refuse transfer under clause (x) shall not affect the resident's eligibility or entitlement to medical assistance under this subchapter or a State's entitlement to Federal medical assistance under this subchapter with respect to services furnished to such a resident.

(B) Notice of rights

A nursing facility must—

(i) inform each resident, orally and in writing at the time of admission to the facility, of the resident's legal rights during the stay at the facility and of the requirements and procedures for establishing eligibility for medical assistance under this subchapter, including the right to request an assessment under section 1396r-5 (c)(1)(B) of this title;

(ii) make available to each resident, upon reasonable request, a written statement of such rights (which statement is updated upon changes in such rights) including the notice (if any) of the State de-

veloped under subsection (e)(6) of this section;

(iii) inform each resident who is entitled to medical assistance under this subchapter—

(I) at the time of admission to the facility or, if later, at the time the resident becomes eligible for such assistance, of the items and services (including those specified under section 1396a(a)(28)(B) of this title) that are included in nursing facility services under the State plan and for which the resident may not be charged (except as permitted in section 1396o of this title), and of those other items and services that the facility offers and for which the resident may be charged and the amount of the charges for such items and services, and

(II) of changes in the items and services described in subclause (I) and of changes in the charges imposed for items and services described in that subclause; and

(iv) inform each other resident, in writing before or at the time of admission and periodically during the resident's stay, of services available in the facility and of related charges for such services, including any charges for services not covered under subchapter XVIII of this chapter or by the facility's basic per diem charge.

The written description of legal rights under this subparagraph shall include a description of the protection of personal funds under paragraph (6) and a statement that a resident may file a complaint with a State survey and certification agency respecting resident abuse and neglect and misappropriation of resident property in the facility.

(C) Rights of incompetent residents

In the case of a resident adjudged incompetent under the laws of a State, the rights of the resident under this subchapter shall devolve upon, and, to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the resident's behalf.

(D) Use of psychopharmacologic drugs

Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the written plan of care described in paragraph (2)) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually an independent, external consultant reviews the appropriateness of the drug plan of each resident receiving such drugs.

(2) Transfer and discharge rights

(A) In general

A nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless—

(i) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;

(ii) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) the safety of individuals in the facility is endangered;

(iv) the health of individuals in the facility would otherwise be endangered;

(v) the resident has failed, after reasonable and appropriate notice, to pay (or to have paid under this subchapter or subchapter XVIII of this chapter on the resident's behalf) for a stay at the facility; or

(vi) the facility ceases to operate.

In each of the cases described in clauses (i) through (iv), the basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in clauses (i) and (ii), the documentation must be made by the resident's physician, and in the case described in clause (iv) the documentation must be made by a physician. For purposes of clause (v), in the case of a resident who becomes eligible for assistance under this subchapter after admission to the facility, only charges which may be imposed under this subchapter shall be considered to be allowable.

(B) Pre-transfer and pre-discharge notice

(i) In general

Before effecting a transfer or discharge of a resident, a nursing facility must—

(I) notify the resident (and, if known, an immediate family member of the resident or legal representative) of the transfer or discharge and the reasons therefor,

(II) record the reasons in the resident's clinical record (including any documentation required under subparagraph (A)), and

(III) include in the notice the items described in clause (iii).

(ii) Timing of notice

The notice under clause (i)(I) must be made at least 30 days in advance of the resident's transfer or discharge except—

(I) in a case described in clause (iii) or (iv) of subparagraph (A);

(II) in a case described in clause (ii) of subparagraph (A), where the resident's health improves sufficiently to allow a more immediate transfer or discharge;

(III) in a case described in clause (i) of subparagraph (A), where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs; or

(IV) in a case where a resident has not resided in the facility for 30 days.

In the case of such exceptions, notice must be given as many days before the date of the transfer or discharge as is practicable.

(iii) Items included in notice

Each notice under clause (i) must include—

(I) for transfers or discharges effected on or after October 1, 1989, notice of the resident's right to appeal the transfer or discharge under the State process established under subsection (e)(3) of this section;

(II) the name, mailing address, and telephone number of the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965 in accordance with section 712 of the Act);

(III) in the case of residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals established under subtitle C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000; and

(IV) in the case of mentally ill residents (as defined in subsection (e)(7)(G)(i) of this section), the mailing address and telephone number of the agency responsible for the protection and advocacy system for mentally ill individuals established under the Protec-

tion and Advocacy for Mentally Ill Individuals Act.

(C) Orientation

A nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(D) Notice on bed-hold policy and readmission

(i) Notice before transfer

Before a resident of a nursing facility is transferred for hospitalization or therapeutic leave, a nursing facility must provide written information to the resident and an immediate family member or legal representative concerning—

(I) the provisions of the State plan under this subchapter regarding the period (if any) during which the resident will be permitted under the State plan to return and resume residence in the facility, and

(II) the policies of the facility regarding such a period, which policies must be consistent with clause (iii).

(ii) Notice upon transfer

At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility must provide written notice to the resident and an immediate family member or legal representative of the duration of any period described in clause (i).

(iii) Permitting resident to return

A nursing facility must establish and follow a written policy under which a resident—

(I) who is eligible for medical assistance for nursing facility services under a State plan,

(II) who is transferred from the facility for hospitalization or therapeutic leave, and

(III) whose hospitalization or therapeutic leave exceeds a period paid for under the State plan for the holding of a bed in the facility for the resident,

will be permitted to be readmitted to the facility immediately upon the first availability of a bed in a semiprivate room in the facility if, at the time of readmission, the resident requires the services provided by the facility.

(E) Information respecting advance directives

A nursing facility must comply with the requirement of section 1396a(w) of this title (relating to maintaining written policies and procedures respecting advance directives).

(F) Continuing rights in case of voluntary withdrawal from participation

(i) In general

In the case of a nursing facility that voluntarily withdraws from participation in a State plan under this subchapter but continues to provide services of the type provided by nursing facilities—

(I) the facility's voluntary withdrawal from participation is not an acceptable basis for the transfer or discharge of residents of the facility who were residing in the facility on the day before the effective date of the withdrawal (including those residents who were not entitled to medical assistance as of such day);

(II) the provisions of this section continue to apply to such residents until the date of their discharge from the facility; and

(III) in the case of each individual who begins residence in the facility after the effective date of such withdrawal, the facility shall provide notice orally and in a prominent manner in writing on a separate page at the time the individual begins residence of the information described in clause (ii) and shall obtain from each such individual at such time an acknowledgment of receipt of such information that is in writing, signed by the individual, and separate from other documents signed by such individual.

Nothing in this subparagraph shall be construed as affecting any requirement of a participation agreement that a nursing facility provide advance notice to the State or the Secretary, or both, of its intention to terminate the agreement.

(ii) Information for new residents

The information described in this clause for a resident is the following:

(I) The facility is not participating in the program under this subchapter with respect to that resident.

(II) The facility may transfer or discharge the resident from the facility at such time as the resident is unable to pay the charges of the facility, even though the resident may have become eligible for medical assistance for nursing facility services under this subchapter.

(iii) Continuation of payments and oversight authority

Notwithstanding any other provision of this subchapter, with respect to the residents described in clause (i)(I), a participation agreement of a facility described in clause (i) is deemed to continue in effect under such plan after the effective date of the facility's voluntary withdrawal from participation under the State plan for purposes of—

(I) receiving payments under the State plan for nursing facility services provided to such residents;

(II) maintaining compliance with all applicable requirements of this subchapter; and

(III) continuing to apply the survey, certification, and enforcement authority provided under subsections (g) and (h)

of this section (including involuntary termination of a participation agreement deemed continued under this clause).

(iv) No application to new residents

This paragraph (other than subclause (III) of clause (i)) shall not apply to an individual who begins residence in a facility on or after the effective date of the withdrawal from participation under this subparagraph.

(3) Access and visitation rights

A nursing facility must—

(A) permit immediate access to any resident by any representative of the Secretary, by any representative of the State, by an ombudsman or agency described in subclause (II), (III), or (IV) of paragraph (2)(B)(iii), or by the resident's individual physician;

(B) permit immediate access to a resident, subject to the resident's right to deny or withdraw consent at any time, by immediate family or other relatives of the resident;

(C) permit immediate access to a resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, by others who are visiting with the consent of the resident;

(D) permit reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and

(E) permit representatives of the State ombudsman (described in paragraph (2)(B)(iii)(II)), with the permission of the resident (or the resident's legal representative) and consistent with State law, to examine a resident's clinical records.

(4) Equal access to quality care

(A) In general

A nursing facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services required under the State plan for all individuals regardless of source of payment.

(B) Construction

(i) Nothing prohibiting any charges for non-medicaid patients

Subparagraph (A) shall not be construed as prohibiting a nursing facility from charging any amount for services furnished, consistent with the notice in paragraph (1)(B) describing such charges.

(ii) No additional services required

Subparagraph (A) shall not be construed as requiring a State to offer additional services on behalf of a resident than are otherwise provided under the State plan.

(5) Admissions policy

(A) Admissions

With respect to admissions practices, a nursing facility must—

(i)

(I) not require individuals applying to reside or residing in the facility to waive their rights to benefits under this subchapter or subchapter XVIII of this chapter,

(II) subject to subparagraph (B)(v), not require oral or written assurance that such individuals are not eligible for, or will not apply for, benefits under this subchapter or subchapter XVIII of this chapter, and

(III) prominently display in the facility written information, and provide to such individuals oral and written information, about how to apply for and use such benefits and how to receive refunds for previous payments covered by such benefits;

(ii) not require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility; and

(iii) in the case of an individual who is entitled to medical assistance for nursing facility services, not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan under this subchapter, any gift, money, donation, or other consideration as a precondition of admitting (or expediting the admission of) the individual to the facility or as a requirement for the individual's continued stay in the facility.

(B) Construction

(i) No preemption of stricter standards

Subparagraph (A) shall not be construed as preventing States or political subdivisions therein from prohibiting, under State or local law, the discrimination against individuals who are entitled to medical assistance under the State plan with respect to admissions practices of nursing facilities.

(ii) Contracts with legal representatives

Subparagraph (A)(ii) shall not be construed as preventing a facility from requiring an individual, who has legal access to a resident's income or resources available to pay for care in the facility, to sign a contract (without incurring personal financial liability) to provide payment from the resident's income or resources for such care.

(iii) Charges for additional services requested

Subparagraph (A)(iii) shall not be construed as preventing a facility from charging a resident, eligible for medical assistance under the State plan, for items or services the resident has requested and received and that are not specified in the State plan as included in the term "nursing facility services".

(iv) Bona fide contributions

Subparagraph (A)(iii) shall not be construed as prohibiting a nursing facility

from soliciting, accepting, or receiving a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the resident (or potential resident), but only to the extent that such contribution is not a condition of admission, expediting admission, or continued stay in the facility.

(v) Treatment of continuing care retirement communities admission contracts

Notwithstanding subclause (II) of subparagraph (A)(i), subject to subsections (c) and (d) of section 1396r-5 of this title, contracts for admission to a State licensed, registered, certified, or equivalent continuing care retirement community or life care community, including services in a nursing facility that is part of such community, may require residents to spend on their care resources declared for the purposes of admission before applying for medical assistance.

(6) Protection of resident funds

(A) In general

The nursing facility—

(i) may not require residents to deposit their personal funds with the facility, and

(ii) upon the written authorization of the resident, must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this paragraph.

(B) Management of personal funds

Upon written authorization of a resident under subparagraph (A)(ii), the facility must manage and account for the personal funds of the resident deposited with the facility as follows:

(i) Deposit

The facility must deposit any amount of personal funds in excess of $50 with respect to a resident in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the facility must maintain such funds in a non-interest bearing account or petty cash fund.

(ii) Accounting and records

The facility must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a resident deposited with the facility, and afford the resident (or a legal representative of the resident) reasonable access to such record.

(iii) Notice of certain balances

The facility must notify each resident receiving medical assistance under the State plan under this subchapter when the amount in the resident's account reaches $200 less than the dollar amount determined under section1382 (a)(3)(B) of this

title and the fact that if the amount in the account (in addition to the value of the resident's other nonexempt resources) reaches the amount determined under such section the resident may lose eligibility for such medical assistance or for benefits under subchapter XVI of this chapter.

(iv) Conveyance upon death

Upon the death of a resident with such an account, the facility must convey promptly the resident's personal funds (and a final accounting of such funds) to the individual administering the resident's estate.

(C) Assurance of financial security

The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

(D) Limitation on charges to personal funds

The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under this subchapter or subchapter XVIII of this chapter.

(7) Limitation on charges in case of medicaid-eligible individuals

(A) In general

A nursing facility may not impose charges, for certain medicaid-eligible individuals for nursing facility services covered by the State

under its plan under this subchapter, that exceed the payment amounts established by the State for such services under this subchapter.

(B) "Certain medicaid-eligible individual" defined

In subparagraph (A), the term "certain medicaid-eligible individual" means an individual who is entitled to medical assistance for nursing facility services in the facility under this subchapter but with respect to whom such benefits are not being paid because, in determining the amount of the individual's income to be applied monthly to payment for the costs of such services, the amount of such income exceeds the payment amounts established by the State for such services under this subchapter.

(8) Posting of survey results

A nursing facility must post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility conducted under subsection (g) of this section.

(d) Requirements relating to administration and other matters

(1) Administration

(A) In general

A nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident (con-

sistent with requirements established under subsection (f)(5) of this section).

(B) Required notices

If a change occurs in—

(i) the persons with an ownership or control interest (as defined in section 1320a-3(a)(3) of this title) in the facility,

(ii) the persons who are officers, directors, agents, or managing employees (as defined in section 1320a-5(b) of this title) of the facility,

(iii) the corporation, association, or other company responsible for the management of the facility, or

(iv) the individual who is the administrator or director of nursing of the facility,

the nursing facility must provide notice to the State agency responsible for the licensing of the facility, at the time of the change, of the change and of the identity of each new person, company, or individual described in the respective clause.

(C) Nursing facility administrator

The administrator of a nursing facility must meet standards established by the Secretary under subsection (f)(4) of this section.

(2) Licensing and Life Safety Code

(A) Licensing

A nursing facility must be licensed under applicable State and local law.

(B) Life Safety Code

A nursing facility must meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes; except that—

(i) the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a facility, but only if such waiver would not adversely affect the health and safety of residents or personnel, and

(ii) the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects residents of and personnel in nursing facilities.

(3) Sanitary and infection control and physical environment

A nursing facility must—

(A) establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection, and

(B) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents, personnel, and the general public.

(4) Miscellaneous

(A) Compliance with Federal, State, and local laws and professional standards

A nursing facility must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations (including the requirements of section 1320a-3 of this title) and with accepted professional standards and principles which apply to professionals providing services in such a facility.

(B) Other

A nursing facility must meet such other requirements relating to the health and safety of residents or relating to the physical facilities thereof as the Secretary may find necessary.

(e) State requirements relating to nursing facility requirements

As a condition of approval of its plan under this subchapter, a State must provide for the following:

(1) Specification and review of nurse aide training and competency evaluation programs and of nurse aide competency evaluation programs

The State must—

(A) by not later than January 1, 1989, specify those training and competency evaluation programs, and those competency evaluation programs, that the State approves for purposes of subsection (b)(5) of this section and that meet the requirements established under subsection (f)(2) of this section, and

(B) by not later than January 1, 1990, provide for the review and reapproval of such

programs, at a frequency and using a methodology consistent with the requirements established under subsection (f)(2)(A)(iii) of this section.

The failure of the Secretary to establish requirements under subsection (f)(2) of this section shall not relieve any State of its responsibility under this paragraph.

(2) Nurse aide registry

(A) In general

By not later than January 1, 1989, the State shall establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program, or a nurse aide competency evaluation program, approved under paragraph (1) in the State, or any individual described in subsection (f)(2)(B)(ii) of this section or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989.

(B) Information in registry

The registry under subparagraph (A) shall provide (in accordance with regulations of the Secretary) for the inclusion of specific documented findings by a State under subsection (g)(1)(C) of this section of resident neglect or abuse or misappropriation of resident property involving an individual listed in the registry, as well as any brief statement of the individual disputing the findings. The State shall make available to the public information in the registry. In the case of inquiries to the reg-

istry concerning an individual listed in the registry, any information disclosed concerning such a finding shall also include disclosure of any such statement in the registry relating to the finding or a clear and accurate summary of such a statement.

(C) Prohibition against charges

A State may not impose any charges on a nurse aide relating to the registry established and maintained under subparagraph (A).

(3) State appeals process for transfers and discharges

The State, for transfers and discharges from nursing facilities effected on or after October 1, 1989, must provide for a fair mechanism, meeting the guidelines established under subsection (f)(3) of this section, for hearing appeals on transfers and discharges of residents of such facilities; but the failure of the Secretary to establish such guidelines under such subsection shall not relieve any State of its responsibility under this paragraph.

(4) Nursing facility administrator standards

By not later than July 1, 1989, the State must have implemented and enforced the nursing facility administrator standards developed under subsection (f)(4) of this section respecting the qualification of administrators of nursing facilities.

(5) Specification of resident assessment instrument

Effective July 1, 1990, the State shall specify the instrument to be used by nursing facilities in

the State in complying with the requirement of subsection (b)(3)(A)(iii) of this section. Such instrument shall be—

(A) one of the instruments designated under subsection (f)(6)(B) of this section, or

(B) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary under subsection (f)(6)(A) of this section.

(6) Notice of medicaid rights

Each State, as a condition of approval of its plan under this subchapter, effective April 1, 1988, must develop (and periodically update) a written notice of the rights and obligations of residents of nursing facilities (and spouses of such residents) under this subchapter.

(7) State requirements for preadmission screening and resident review

(A) Preadmission screening

(i) In general

Effective January 1, 1989, the State must have in effect a preadmission screening program, for making determinations (using any criteria developed under subsection (f)(8) of this section) described in subsection (b)(3)(F) of this section for mentally ill and mentally retarded individuals (as defined in subparagraph (G)) who are admitted to nursing facilities on or after January 1, 1989. The failure of the Secretary to develop minimum criteria under

subsection (f)(8) of this section shall not relieve any State of its responsibility to have a preadmission screening program under this subparagraph or to perform resident reviews under subparagraph (B).

(ii) Clarification with respect to certain readmissions

The preadmission screening program under clause (i) need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

(iii) Exception for certain hospital discharges

The preadmission screening program under clause (i) shall not apply to the admission to a nursing facility of an individual—

(I) who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

(II) who requires nursing facility services for the condition for which the individual received care in the hospital, and

(III) whose attending physician has certified, before admission to the facility, that the individual is likely to require less than 30 days of nursing facility services.

(B) State requirement for resident review

(i) For mentally ill residents

As of April 1, 1990, in the case of each resident of a nursing facility who is mentally ill, the State mental health authority must review and determine (using any criteria developed under subsection (f)(8) of this section and based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority)—

(I) whether or not the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an inpatient psychiatric hospital for individuals under age 21 (as described in section 1396d(h) of this title) or of an institution for mental diseases providing medical assistance to individuals 65 years of age or older; and

(II) whether or not the resident requires specialized services for mental illness.

(ii) For mentally retarded residents As of April 1, 1990, in the case of each resident of a nursing facility who is mentally retarded, the State mental retardation or developmental disability authority must review and determine (using any criteria developed under subsection (f)(8) of this section)—

(I) whether or not the resident, because of the resident's physical and

mental condition, requires the level of services provided by a nursing facility or requires the level of services of an intermediate care facility described under section 1396d(d) of this title; and

(II) whether or not the resident requires specialized services for mental retardation.

(iii) Review required upon change in resident's condition

A review and determination under clause (i) or (ii) must be conducted promptly after a nursing facility has notified the State mental health authority or State mental retardation or developmental disability authority, as applicable, under subsection (b)(3)(E) of this section with respect to a mentally ill or mentally retarded resident, that there has been a significant change in the resident's physical or mental condition.

(iv) Prohibition of delegation

A State mental health authority, a State mental retardation or developmental disability authority, and a State may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility).

(C) Response to preadmission screening and resident review

As of April 1, 1990, the State must meet the following requirements:

(i) Long-term residents not requiring nursing facility services, but requiring specialized services

In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility, but to require specialized services for mental illness or mental retardation, and who has continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must, in consultation with the resident's family or legal representative and care-givers—

(I) inform the resident of the institutional and noninstitutional alternatives covered under the State plan for the resident,

(II) offer the resident the choice of remaining in the facility or of receiving covered services in an alternative appropriate institutional or noninstitutional setting,

(III) clarify the effect on eligibility for services under the State plan if the resident chooses to leave the facility (including its effect on readmission to the facility), and

(IV) regardless of the resident's choice, provide for (or arrange for the provision of) such specialized services

for the mental illness or mental retardation.

A State shall not be denied payment under this subchapter for nursing facility services for a resident described in this clause because the resident does not require the level of services provided by such a facility, if the resident chooses to remain in such a facility.

(ii) Other residents not requiring nursing facility services, but requiring specialized services

In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility, but to require specialized services for mental illness or mental retardation, and who has not continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must, in consultation with the resident's family or legal representative and care-givers—

(I) arrange for the safe and orderly discharge of the resident from the facility, consistent with the requirements of subsection (c)(2) of this section,

(II) prepare and orient the resident for such discharge, and

(III) provide for (or arrange for the provision of) such specialized services for the mental illness or mental retardation.

(iii) Residents not requiring nursing facility services and not requiring specialized services

In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility and not to require specialized services for mental illness or mental retardation, the State must—

(I) arrange for the safe and orderly discharge of the resident from the facility, consistent with the requirements of subsection (c)(2) of this section, and

(II) prepare and orient the resident for such discharge.

(iv) Annual report

Each State shall report to the Secretary annually concerning the number and disposition of residents described in each of clauses (ii) and (iii).

(D) Denial of payment

(i) For failure to conduct preadmission screening or review No payment may be made under section 1396b(a) of this title with respect to nursing facility services furnished to an individual for whom a determination is required under subsection (b)(3)(F) of this section or subparagraph (B) but for whom the determination is not made.

(ii) For certain residents not requiring nursing facility level of services No payment may be made under section 1396b(a)

of this title with respect to nursing facility services furnished to an individual (other than an individual described in subparagraph (C)(i)) who does not require the level of services provided by a nursing facility.

(E) Permitting alternative disposition plans

With respect to residents of a nursing facility who are mentally retarded or mentally ill and who are determined under subparagraph (B) not to require the level of services of such a facility, but who require specialized services for mental illness or mental retardation, a State and the nursing facility shall be considered to be in compliance with the requirements of subparagraphs (A) through (C) of this paragraph if, before April 1, 1989, the State and the Secretary have entered into an agreement relating to the disposition of such residents of the facility and the State is in compliance with such agreement. Such an agreement may provide for the disposition of the residents after the date specified in subparagraph (C). The State may revise such an agreement, subject to the approval of the Secretary, before October 1, 1991, but only if, under the revised agreement, all residents subject to the agreement who do not require the level of services of such a facility are discharged from the facility by not later than April 1, 1994.

(F) Appeals procedures

Each State, as a condition of approval of its plan under this subchapter, effective January

1, 1989, must have in effect an appeals process for individuals adversely affected by determinations under subparagraph (A) or (B).

(G) Definitions

In this paragraph and in subsection (b)(3)(F) of this section:

(i) An individual is considered to be "mentally ill" if the individual has a serious mental illness (as defined by the Secretary in consultation with the National Institute of Mental Health) and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) or a diagnosis (other than a primary diagnosis) of dementia and a primary diagnosis that is not a serious mental illness.

(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded or a person with a related condition (as described in section 1396d(d) of this title).

(iii) The term "specialized services" has the meaning given such term by the Secretary in regulations, but does not include, in the case of a resident of a nursing facility, services within the scope of services which the facility must provide or arrange for its residents under subsection (b)(4) of this section.

(f) Responsibilities of Secretary relating to nursing facility requirements

(1) General responsibility

It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in nursing facilities under State plans approved under this subchapter, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.

(2) Requirements for nurse aide training and competency evaluation programs and for nurse aide competency evaluation programs

(A) In general

For purposes of subsections (b)(5) and (e)(1)(A) of this section, the Secretary shall establish, by not later than September 1, 1988—

(i) requirements for the approval of nurse aide training and competency evaluation programs, including requirements relating to

(I) the areas to be covered in such a program (including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights) and content of the curriculum,

(II) minimum hours of initial and ongoing training and retraining (including not less than 75 hours in the case of initial training),

(III) qualifications of instructors, and

(IV) procedures for determination of competency;

(ii) requirements for the approval of nurse aide competency evaluation programs, including requirement relating to the areas to be covered in such a program, including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights, and procedures for determination of competency;

(iii) requirements respecting the minimum frequency and methodology to be used by a State in reviewing such programs' compliance with the requirements for such programs; and

(iv) requirements, under both such programs, that—

(I) provide procedures for determining competency that permit a nurse aide, at the nurse aide's option, to establish competency through procedures or methods other than the passing of a written examination and to have the competency evaluation conducted at the nursing facility at which the aide is (or will be) employed (unless the facility is described in subparagraph (B)(iii)(I)),

(II) prohibit the imposition on a nurse aide who is employed by (or who has received an offer of employment from) a facility on the date on which the

aide begins either such program of any charges (including any charges for textbooks and other required course materials and any charges for the competency evaluation) for either such program, and

(III) in the case of a nurse aide not described in subclause (II) who is employed by (or who has received an offer of employment from) a facility not later than 12 months after completing either such program, the State shall provide for the reimbursement of costs incurred in completing such program on a prorata basis during the period in which the nurse aide is so employed.

(B) Approval of certain programs

Such requirements—

(i) may permit approval of programs offered by or in facilities, as well as outside facilities (including employee organizations), and of programs in effect on December 22, 1987;

(ii) shall permit a State to find that an individual who has completed (before July 1, 1989) a nurse aide training and competency evaluation program shall be deemed to have completed such a program approved under subsection (b)(5) of this section if the State determines that, at the time the program was offered, the program met the requirements for approval under such paragraph; and

(iii) subject to subparagraphs (C) and (D), shall prohibit approval of such a program—

(I) offered by or in a nursing facility which, within the previous 2 years—

(a) has operated under a waiver under subsection (b)(4)(C)(ii) of this section that was granted on the basis of a demonstration that the facility is unable to provide the nursing care required under subsection (b)(4)(C)(i) of this section for a period in excess of 48 hours during a week;

(b) has been subject to an extended (or partial extended) survey under section 1395i-3(g)(2)(B)(i) of this title or subsection (g)(2)(B)(i) of this section; or

(c) has been assessed a civil money penalty described in section 1395i-3(h)(2)(B)(ii) of this title or subsection (h)(2)(A)(ii) of this section of not less than $5,000, or has been subject to a remedy described in subsection (h)(1)(B)(i) of this section, clauses (i), (iii), or (iv) of subsection (h)(2)(A) of this section, clauses (i) or (iii) of section 1395i-3(h)(2)(B) of this title, or section 1395i-3(h)(4) of this title, or

(II) offered by or in a nursing facility unless the State makes the determination, upon an individual's completion of the program, that the individual is

competent to provide nursing and nursing-related services in nursing facilities.

A State may not delegate (through subcontract or otherwise) its responsibility under clause (iii)(II) to the nursing facility.

(C) Waiver authorized

Clause (iii)(I) of subparagraph (B) shall not apply to a program offered in (but not by) a nursing facility (or skilled nursing facility for purposes of subchapter XVIII of this chapter) in a State if the State—

(i) determines that there is no other such program offered within a reasonable distance of the facility,

(ii) assures, through an oversight effort, that an adequate environment exists for operating the program in the facility, and

(iii) provides notice of such determination and assurances to the State long-term care ombudsman.

(D) Waiver of disapproval of nurse-aide training programs

Upon application of a nursing facility, the Secretary may waive the application of subparagraph (B)(iii)(I)(c) if the imposition of the civil monetary penalty was not related to the quality of care provided to residents of the facility. Nothing in this subparagraph shall be construed as eliminating any requirement upon a facility to pay a civil monetary penalty described in the preceding sentence.

(3) Federal guidelines for State appeals process for transfers and discharges

For purposes of subsections (c)(2)(B)(iii) and (e)(3) of this section, by not later than October 1, 1988, the Secretary shall establish guidelines for minimum standards which State appeals processes under subsection (e)(3) of this section must meet to provide a fair mechanism for hearing appeals on transfers and discharges of residents from nursing facilities.

(4) Secretarial standards qualification of administrators

For purposes of subsections (d)(1)(C) and (e)(4) of this section, the Secretary shall develop, by not later than March 1, 1988, standards to be applied in assuring the qualifications of administrators of nursing facilities.

(5) Criteria for administration

The Secretary shall establish criteria for assessing a nursing facility's compliance with the requirement of subsection (d)(1) of this section with respect to—

(A) its governing body and management,

(B) agreements with hospitals regarding transfers of residents to and from the hospitals and to and from other nursing facilities,

(C) disaster preparedness,

(D) direction of medical care by a physician,

(E) laboratory and radiological services,

(F) clinical records, and

(G) resident and advocate participation.

(6) Specification of resident assessment data set and instruments

The Secretary shall—

(A) not later than January 1, 1989, specify a minimum data set of core elements and common definitions for use by nursing facilities in conducting the assessments required under subsection (b)(3) of this section, and establish guidelines for utilization of the data set; and

(B) by not later than April 1, 1990, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subsection (e)(5)(A) of this section for use by nursing facilities in complying with the requirements of subsection (b)(3)(A)(iii) of this section.

(7) List of items and services furnished in nursing facilities not chargeable to the personal funds of a resident

(A) Regulations required

Pursuant to the requirement of section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, the Secretary shall issue regulations, on or before the first day of the seventh month to begin after December 22, 1987, that define those costs which may be charged to the personal funds of residents in nursing facilities who are individuals receiving medical assistance with respect to nursing facility services under this subchapter and those costs which are to be included in the payment amount under this subchapter for nursing facility services.

(B) Rule if failure to publish regulations

If the Secretary does not issue the regulations under subparagraph (A) on or before the date required in that subparagraph, in the case of a resident of a nursing facility who is eligible to receive benefits for nursing facility services under this subchapter, for purposes of section 1396a(a)(28)(B) of this title, the Secretary shall be deemed to have promulgated regulations under this paragraph which provide that the costs which may not be charged to the personal funds of such resident (and for which payment is considered to be made under this subchapter) include, at a minimum, the costs for routine personal hygiene items and services furnished by the facility.

(8) Federal minimum criteria and monitoring for preadmission screening and resident review

(A) Minimum criteria

The Secretary shall develop, by not later than October 1, 1988, minimum criteria for States to use in making determinations under subsections (b)(3)(F) and (e)(7)(B) of this section and in permitting individuals adversely affected to appeal such determinations, and shall notify the States of such criteria.

(B) Monitoring compliance

The Secretary shall review, in a sufficient number of cases to allow reasonable inferences, each State's compliance with the requirements of subsection (e)(7)(C)(ii) of this section (relating to discharge and placement for active treatment of certain residents).

(9) Criteria for monitoring State waivers

The Secretary shall develop, by not later than October 1, 1988, criteria and procedures for monitoring State performances in granting waivers pursuant to subsection (b)(4)(C)(ii) of this section.

(g) Survey and certification process

(1) State and Federal responsibility

(A) In general

Under each State plan under this subchapter, the State shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of nursing facilities (other than facilities of the State) with the requirements of subsections (b), (c), and (d) of this section. The Secretary shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of State nursing facilities with the requirements of such subsections.

(B) Educational program

Each State shall conduct periodic educational programs for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies under this section.

(C) Investigation of allegations of resident neglect and abuse and misappropriation of resident property

The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and

abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility in providing services to such a resident. The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority. A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.

(D) Removal of name from nurse aide registry

(i) In general

In the case of a finding of neglect under subparagraph (C), the State shall establish a procedure to permit a nurse aide to petition the State to have his or her name removed from the registry upon a determination by the State that—

(I) the employment and personal history of the nurse aide does not reflect a

pattern of abusive behavior or neglect; and

(II) the neglect involved in the original finding was a singular occurrence.

(ii) Timing of determination

In no case shall a determination on a petition submitted under clause (i) be made prior to the expiration of the 1-year period beginning on the date on which the name of the petitioner was added to the registry under subparagraph (C).

(E) Construction

The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

(2) Surveys

(A) Annual standard survey

(i) In general

Each nursing facility shall be subject to a standard survey, to be conducted without any prior notice to the facility. Any individual who notifies (or causes to be notified) a nursing facility of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title. The

Secretary shall review each State's procedures for scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(ii) Contents

Each standard survey shall include, for a case-mix stratified sample of residents—

(I) a survey of the quality of care furnished, as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition services, activities and social participation, and sanitation, infection control, and the physical environment,

(II) written plans of care provided under subsection (b)(2) of this section and an audit of the residents' assessments under subsection (b)(3) of this section to determine the accuracy of such assessments and the adequacy of such plans of care, and

(III) a review of compliance with residents' rights under subsection (c) of this section.

(iii) Frequency

(I) In general

Each nursing facility shall be subject to a standard survey not later than 15 months after the date of the previous standard survey conducted under this

subparagraph. The statewide average interval between standard surveys of a nursing facility shall not exceed 12 months.

(II) Special surveys

If not otherwise conducted under subclause (I), a standard survey (or an abbreviated standard survey) may be conducted within 2 months of any change of ownership, administration, management of a nursing facility, or director of nursing in order to determine whether the change has resulted in any decline in the quality of care furnished in the facility.

(B) Extended surveys

(i) In general

Each nursing facility which is found, under a standard survey, to have provided substandard quality of care shall be subject to an extended survey. Any other facility may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey).

(ii) Timing

The extended survey shall be conducted immediately after the standard survey (or, if not practicable, not later than 2 weeks after the date of completion of the standard survey).

(iii) Contents

In such an extended survey, the survey team shall review and identify the policies

and procedures which produced such substandard quality of care and shall determine whether the facility has complied with all the requirements described in subsections (b), (c), and (d) of this section. Such review shall include an expansion of the size of the sample of residents' assessments reviewed and a review of the staffing, of in-service training, and, if appropriate, of contracts with consultants.

(iv) Construction

Nothing in this paragraph shall be construed as requiring an extended or partial extended survey as a prerequisite to imposing a sanction against a facility under subsection (h) of this section on the basis of findings in a standard survey.

(C) Survey protocol

Standard and extended surveys shall be conducted—

(i) based upon a protocol which the Secretary has developed, tested, and validated by not later than January 1, 1990, and

(ii) by individuals, of a survey team, who meet such minimum qualifications as the Secretary establishes by not later than such date.

The failure of the Secretary to develop, test, or validate such protocols or to establish such minimum qualifications shall not relieve any State of its responsibility (or the Secretary of the Secretary's responsibility) to conduct surveys under this subsection.

(D) Consistency of surveys

Each State shall implement programs to measure and reduce inconsistency in the application of survey results among surveyors.

(E) Survey teams

(i) In general

Surveys under this subsection shall be conducted by a multidisciplinary team of professionals (including a registered professional nurse).

(ii) Prohibition of conflicts of interest

A State may not use, as a member of a survey team under this subsection an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the facility surveyed respecting compliance with the requirements of subsections (b), (c), and (d) of this section, or who has a personal or familial financial interest in the facility being surveyed.

(iii) Training

The Secretary shall provide for the comprehensive training of State and Federal surveyors in the conduct of standard and extended surveys under this subsection, including the auditing of resident assessments and plans of care. No individual shall serve as a member of a survey team unless the individual has successfully completed a training and testing program in

survey and certification techniques that has been approved by the Secretary.

(3) Validation surveys

(A) In general

The Secretary shall conduct onsite surveys of a representative sample of nursing facilities in each State, within 2 months of the date of surveys conducted under paragraph (2) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under paragraph (2). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under paragraph (2). If the State has determined that an individual nursing facility meets the requirements of subsections (b), (c), and (d) of this section, but the Secretary determines that the facility does not meet such requirements, the Secretary's determination as to the facility's noncompliance with such requirements is binding and supersedes that of the State survey.

(B) Scope

With respect to each State, the Secretary shall conduct surveys under subparagraph (A) each year with respect to at least 5 percent of the number of nursing facilities surveyed by the State in the year, but in no case less than 5 nursing facilities in the State.

(C) Reduction in administrative costs for substandard performance

If the Secretary finds, on the basis of such surveys, that a State has failed to perform

surveys as required under paragraph (2) or that a State's survey and certification performance otherwise is not adequate, the Secretary may provide for the training of survey teams in the State and shall provide for a reduction of the payment otherwise made to the State under section 1396b(a)(2)(D) of this title with respect to a quarter equal to 33 percent multiplied by a fraction, the denominator of which is equal to the total number of residents in nursing facilities surveyed by the Secretary that quarter and the numerator of which is equal to the total number of residents in nursing facilities which were found pursuant to such surveys to be not in compliance with any of the requirements of subsections (b), (c), and (d) of this section. A State that is dissatisfied with the Secretary's findings under this subparagraph may obtain reconsideration and review of the findings under section 1316 of this title in the same manner as a State may seek reconsideration and review under that section of the Secretary's determination under section 1316(a)(1) of this title.

(D) Special surveys of compliance

Where the Secretary has reason to question the compliance of a nursing facility with any of the requirements of subsections (b), (c), and (d) of this section, the Secretary may conduct a survey of the facility and, on the basis of that survey, make independent and binding determinations concerning the extent to which the nursing facility meets such requirements.

(4) Investigation of complaints and monitoring nursing facility compliance

Each State shall maintain procedures and adequate staff to—

(A) investigate complaints of violations of requirements by nursing facilities, and

(B) monitor, on-site, on a regular, as needed basis, a nursing facility's compliance with the requirements of subsections (b), (c), and (d) of this section, if—

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements, has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

A State may maintain and utilize a specialized team (including an attorney, an auditor, and appropriate health care professionals) for the purpose of identifying, surveying, gathering and preserving evidence, and carrying out appropriate enforcement actions against substandard nursing facilities.

(5) Disclosure of results of inspections and activities

(A) Public information

Each State, and the Secretary, shall make available to the public—

(i) information respecting all surveys and certifications made respecting nursing facilities, including statements of deficiencies, within 14 calendar days after such information is made available to those facilities, and approved plans of correction,

(ii) copies of cost reports of such facilities filed under this subchapter or under subchapter XVIII of this chapter,

(iii) copies of statements of ownership under section 1320a-3 of this title, and

(iv) information disclosed under section 1320a-5 of this title.

(B) Notice to ombudsman

Each State shall notify the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965 in accordance with section 712 of the Act) of the State's findings of noncompliance with any of the requirements of subsections (b), (c), and (d) of this section, or of any adverse action taken against a nursing facility under paragraphs (1), (2), or (3) of subsection (h) of this section, with respect to a nursing facility in the State.

(C) Notice to physicians and nursing facility administrator licensing board

If a State finds that a nursing facility has provided substandard quality of care, the State shall notify—

(i) the attending physician of each resident with respect to which such finding is made, and

(ii) any State board responsible for the licensing of the nursing facility administrator of the facility.

(D) Access to fraud control units

Each State shall provide its State medicaid fraud and abuse control unit (established under section 1396b(q) of this title) with access to all information of the State agency responsible for surveys and certifications under this subsection.

(h) Enforcement process

(1) In general

If a State finds, on the basis of a standard, extended, or partial extended survey under subsection (g)(2) of this section or otherwise, that a nursing facility no longer meets a requirement of subsection (b), (c), or (d) of this section, and further finds that the facility's deficiencies—

(A) immediately jeopardize the health or safety of its residents, the State shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(A)(iii), or terminate the facility's participation under the State plan and may provide, in addition, for one or more of the other remedies described in paragraph (2); or

(B) do not immediately jeopardize the health or safety of its residents, the State may—

(i) terminate the facility's participation under the State plan,

(ii) provide for one or more of the remedies described in paragraph (2), or

(iii) do both.

Nothing in this paragraph shall be construed as restricting the remedies available to a State to remedy a nursing facility's deficiencies. If a State finds that a nursing facility meets the requirements of subsections (b), (c), and (d) of this section, but, as of a previous period, did not meet such requirements, the State may provide for a civil money penalty under paragraph (2)(A)(ii) for the days in which it finds that the facility was not in compliance with such requirements.

(2) Specified remedies

(A) Listing

Except as provided in subparagraph (B)(ii), each State shall establish by law (whether statute or regulation) at least the following remedies:

(i) Denial of payment under the State plan with respect to any individual admitted to the nursing facility involved after such notice to the public and to the facility as may be provided for by the State.

(ii) A civil money penalty assessed and collected, with interest, for each day in which the facility is or was out of compliance with a requirement of subsection (b), (c), or (d) of this section. Funds collected by a State as a result of imposition of such a

penalty (or as a result of the imposition by the State of a civil money penalty for activities described in subsections (b)(3)(B)(ii)(I), (b)(3)(B)(ii)(II), or (g)(2)(A)(i) of this section) shall be applied to the protection of the health or property of residents of nursing facilities that the State or the Secretary finds deficient, including payment for the costs of relocation of residents to other facilities, maintenance of operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for personal funds lost.

(iii) The appointment of temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d) of this section.

The temporary management under this clause shall not be terminated under subclause (II) until the State has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d) of this section.

(iv) The authority, in the case of an emergency, to close the facility, to transfer

residents in that facility to other facilities, or both.

The State also shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the State may provide for other specified remedies, such as directed plans of correction.

(B) Deadline and guidance

(i) Except as provided in clause (ii), as a condition for approval of a State plan for calendar quarters beginning on or after October 1, 1989, each State shall establish the remedies described in clauses (i) through (iv) of subparagraph (A) by not later than October 1, 1989. The Secretary shall provide, through regulations by not later than October 1, 1988, guidance to States in establishing such remedies; but the failure of the Secretary to provide such guidance shall not relieve a State of the responsibility for establishing such remedies.

(ii) A State may establish alternative remedies (other than termination of participation) other than those described in clauses (i) through (iv) of subparagraph (A), if the State demonstrates to the Secretary's

satisfaction that the alternative remedies are as effective in deterring noncompliance and correcting deficiencies as those described in subparagraph (A).

(C) Assuring prompt compliance

If a nursing facility has not complied with any of the requirements of subsections (b), (c), and (d) of this section, within 3 months after the date the facility is found to be out of compliance with such requirements, the State shall impose the remedy described in suoparagraph (A)(i) for all individuals who are admitted to the facility after such date.

(D) Repeated noncompliance

In the case of a nursing facility which, on 3 consecutive standard surveys conducted under subsection (g)(2) of this section, has been found to have provided substandard quality of care, the State shall (regardless of what other remedies are provided)—

(i) impose the remedy described in subparagraph (A)(i), and

(ii) monitor the facility under subsection (g)(4)(B) of this section,

until the facility has demonstrated, to the satisfaction of the State, that it is in compliance with the requirements of subsections (b), (c), and (d) of this section, and that it will remain in compliance with such requirements.

(E) Funding

The reasonable expenditures of a State to provide for temporary management and other expenses associated with implementing the

remedies described in clauses (iii) and (iv) of subparagraph (A) shall be considered, for purposes of section 1396b(a)(7) of this title, to be necessary for the proper and efficient administration of the State plan.

(F) Incentives for high quality care

In addition to the remedies specified in this paragraph, a State may establish a program to reward, through public recognition, incentive payments, or both, nursing facilities that provide the highest quality care to residents who are entitled to medical assistance under this subchapter. For purposes of section 1396b(a)(7) of this title, proper expenses incurred by a State in carrying out such a program shall be considered to be expenses necessary for the proper and efficient administration of the State plan under this subchapter.

(3) Secretarial authority

(A) For State nursing facilities

With respect to a State nursing facility, the Secretary shall have the authority and duties of a State under this subsection, including the authority to impose remedies described in clauses (i), (ii), and (iii) of paragraph (2)(A).

(B) Other nursing facilities

With respect to any other nursing facility in a State, if the Secretary finds that a nursing facility no longer meets a requirement of subsection (b), (c), (d), or (e) of this section, and further finds that the facility's deficiencies—

(i) immediately jeopardize the health or safety of its residents, the Secretary shall

take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subparagraph (C)(iii), or terminate the facility's participation under the State plan and may provide, in addition, for one or more of the other remedies described in subparagraph (C); or

(ii) do not immediately jeopardize the health or safety of its residents, the Secretary may impose any of the remedies described in subparagraph (C).

Nothing in this subparagraph shall be construed as restricting the remedies available to the Secretary to remedy a nursing facility's deficiencies. If the Secretary finds that a nursing facility meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (C)(ii) for the days on which he finds that the facility was not in compliance with such requirements.

(C) Specified remedies

The Secretary may take the following actions with respect to a finding that a facility has not met an applicable requirement:

(i) Denial of payment

The Secretary may deny any further payments to the State for medical assistance furnished by the facility to all individuals in the facility or to individuals admitted to the facility after the effective date of the finding.

(ii) Authority with respect to civil money penalties

The Secretary may impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(iii) Appointment of temporary management

In consultation with the State, the Secretary may appoint temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d) of this section.

The State also shall specify criteria this clause shall not be terminated under subclause (II) until the Secretary has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d) of this section.

The Secretary shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the Secretary may provide for other specified remedies, such as directed plans of correction.

(D) Continuation of payments pending remediation

The Secretary may continue payments, over a period of not longer than 6 months after the effective date of the findings, under this subchapter with respect to a nursing facility not in compliance with a requirement of subsection (b), (c), or (d) of this section, if—

(i) the State survey agency finds that it is more appropriate to take alternative action to assure compliance of the facility with the requirements than to terminate the certification of the facility, and

(ii) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action.

The Secretary shall establish guidelines for approval of corrective actions requested by States under this subparagraph.

(4) Effective period of denial of payment

A finding to deny payment under this subsection shall terminate when the State or Secretary (or both, as the case may be) finds that the facility is in substantial compliance with all the requirements of subsections (b), (c), and (d) of this section.

(5) Immediate termination of participation for facility where State or Secretary finds noncompliance and immediate jeopardy

If either the State or the Secretary finds that a nursing facility has not met a requirement of subsection (b), (c), or (d) of this section, and finds that the failure immediately jeopardizes the health or safety of its residents, the State or the Secretary, respectively shall notify the other of such finding, and the State or the Secretary, respectively, shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(A)(iii) or (3)(C)(iii), or terminate the facility's participation under the State plan. If the facility's participation in the State plan is terminated by either the State or the Secretary, the State shall provide for the safe and orderly transfer of the residents eligible under the State plan consistent with the requirements of subsection (c)(2) of this section.

(6) Special rules where State and Secretary do not agree on finding of noncompliance

(A) State finding of noncompliance and no secretarial finding of noncompliance

If the Secretary finds that a nursing facility has met all the requirements of subsections (b), (c), and (d) of this section, but a State finds that the facility has not met such requirements and the failure does not immediately jeopardize the health or safety of its residents, the State's findings shall control and the remedies imposed by the State shall be applied.

(B) Secretarial finding of noncompliance and no State finding of noncompliance

If the Secretary finds that a nursing facility has not met all the requirements of subsections (b), (c), and (d) of this section, and that the failure does not immediately jeopardize the health or safety of its residents, but the State has not made such a finding, the Secretary—

(i) may impose any remedies specified in paragraph (3)(C) with respect to the facility, and

(ii) shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(D).

(7) Special rules for timing of termination of participation where remedies overlap

If both the Secretary and the State find that a nursing facility has not met all the requirements of subsections (b), (c), and (d) of this section, and neither finds that the failure immediately jeopardizes the health or safety of its residents—

(A)

(i) if both find that the facility's participation under the State plan should be terminated, the State's timing of any termination shall control so long as the termination date does not occur later than 6 months after the date of the finding to terminate;

(ii) if the Secretary, but not the State, finds that the facility's participation under the State plan should be terminated, the Secretary shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(D); or

(iii) if the State, but not the Secretary, finds that the facility's participation under the State plan should be terminated, the State's decision to terminate, and timing of such termination, shall control; and

(B)

(i) if the Secretary or the State, but not both, establishes one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the State plan, such additional or alternative remedies shall also be applied, or

(ii) if both the Secretary and the State establish one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the State plan, only the additional or alternative remedies of the Secretary shall apply.

(8) Construction

The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. The remedies described in clauses (i), (iii), and (iv) of paragraph (2)(A) may be imposed during the pendency of any hearing. The provisions of this subsection shall apply to a nursing facility (or portion thereof) notwithstanding that the facility (or portion thereof) also is a skilled nursing facility for purposes of subchapter XVIII of this chapter.

(9) Sharing of information

Notwithstanding any other provision of law, all information concerning nursing facilities required by this section to be filed with the Secretary or a State agency shall be made available by such facilities to Federal or State employees for purposes consistent with the effective administration of programs established under this subchapter and subchapter XVIII of this chapter, including investigations by State medicaid fraud control units.

***(i)* Construction**

Where requirements or obligations under this section are identical to those provided under section 1395i-3 of this title, the fulfillment of those requirements or obligations under section 1395i-3 of this title shall be considered to be the fulfillment of the corresponding requirements or obligations under this section.

6. Section 1983 of Title 42, United States Code, provides:

§ 1983. Civil action for deprivation of rights

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

7. Section 1988 of Title 42, United States Code, provides, in relevant part:

§ 1988. Proceedings in vindication of civil rights

* * * * *

(b) Attorney's fees

In any action or proceeding to enforce a provision of sections 1981, 1981a, 1982, 1983, 1985, and 1986 of this title, . . . the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee as part of the costs . . . .

* * * * *

8. The Civil Rights Act of 1871, ch. 22, § 1, 17 Stat. 13, provides:

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That any person who, under color of any law, statute, ordinance, regulation, custom, or usage of any State, shall subject, or cause to be subjected, any person within the jurisdiction of the United States to the deprivation of any rights, privileges, or immunities secured by the Constitution of the United States, shall, any such law, statute, ordinance, regulation, custom, or usage of the State to the contrary notwithstanding, be liable to the party injured in any action at law, suit in equity, or other proper proceeding for redress; such proceeding to be prosecuted in the several district or circuit courts of the United States, with and subject to the same rights of appeal, review upon error, and other remedies provided in like cases in such courts, under the provisions of the act of the ninth of April, eighteen hundred and sixty-six, entitled "An act to protect all persons in the United States in their civil rights, and to furnish the means of their vindication"; and the other remedial laws of the United States which are in their nature applicable in such cases.

9. Section 1979 of the Revised Statutes (1874), provides:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liaable [*sic*] to the

party injured in an action at law, suit in equity, or other proper proceeding for redress.